

MONTANA LEGISLATIVE HISTORY

Chapter 472 19 99

Bill H 100 S _____ Original bill & history / c

H. Committee on Business + Labor

Hearing Date(s) 1-11 ✓ c

2-12 ✓ c

_____ c

_____ c

Date Out 2/23 _____ c

S. Committee on Business + Industry

Hearing Date(s) 3-9 ✓ c

3-12 ✓ c

_____ c

Free Conf.

Committee 4-13 ✓ 3/17 _____ c
- Ex. 1 not on Law
Library CD - see
Historical Society for
original

Did this bill originate in an interim committee? _____ Yes _____ No

Committee _____

Report _____

LEGISLATIVE HISTORIES

The 1997 Montana Legislature dramatically changed the nature of legislative minutes. This altered format continues with the 1999 legislative minutes. The minutes from House committees are extremely sparse in content, offering no substantive information from which to glean legislative intent. The Senate committees' minutes are fuller in content.

Exhibits, which include written statements, attendant information, roll call votes, roll call attendance, a list of those from the public who were present, and specific action taken on legislative bills, will be available only through the Historical Society Archives, 444-4774, and from a CD-ROM produced by the Legislative Services Division, 444-3064.

Just as in the 1997 legislative session, the 1999 House and Senate committee hearings were recorded. For information on accessing the tapes, or purchasing them, contact the Archives, 444-4774.

If you have concerns over the format of these legislative minutes, it is suggested that you contact your state legislators.

4/14 Signed by Speaker
 4/15 Signed by President
 4/16 Transmitted to Governor
 4/20 Signed by Governor
 4/22 Chapter Number Assigned
 Chapter Number 361
 Effective Date: 10/01/1999 - All Sections

HB 99 Introduced by Hagener *LC0934 Drafter: B. Campbell*

Change the Final Date That Notice Must Be Given by the City Treasurer or Town Clerk to Property Owners for Delinquent Sewer Charges from July 15 to July 7;...

12/18 Introduced
 12/23 Referred to Local Government
 1/04 1st Reading
 1/14 Hearing
 1/15 Committee Executive Action--Bill Passed as Amended 18 0
 1/15 Committee Report--Bill Passed as Amended
 1/18 2nd Reading Passed 94 5
 1/19 3rd Reading Passed 89 9

Transmitted to Senate
 1/27 Referred to Local Government
 3/02 Hearing
 3/05 Committee Executive Action--Bill Concurred as Amended 7 0
 3/05 Committee Report--Bill Concurred as Amended
 3/08 2nd Reading Concurred 50 0
 3/09 3rd Reading Concurred 50 0

Returned to House with Amendments
 4/09 2nd Reading Senate Amendments Concurred 94 0
 4/10 3rd Reading Passed as Amended by Senate 91 8
 4/10 Sent to Enrolling
 4/12 Returned from Enrolling
 4/13 Signed by Speaker
 4/14 Signed by President
 4/15 Transmitted to Governor
 4/22 Signed by Governor
 4/23 Chapter Number Assigned
 Chapter Number 423
 Effective Date: 10/01/1999 - All Sections

3 100 Introduced by Simon *LC0370 Drafter: B. Campbell*

Generally Revise Laws Administered by the State Auditor;...

By Request of State Auditor

12/18 Introduced
 12/23 Referred to Business and Labor
 1/04 1st Reading
 1/04 Fiscal Note Requested
 1/08 Fiscal Note Received
 1/08 Fiscal Note Printed
 1/11 Hearing
 1/11 Tabled in Committee
 2/12 Taken from Table in Committee

2/18 Committee Executive Action--Bill Passed as Amended 16 2
 2/19 Committee Report--Bill Passed as Amended
 2/22 2nd Reading Passed 85 13
 2/23 3rd Reading Passed 88 12

Transmitted to Senate
 2/23 Referred to Business and Industry
 3/09 Hearing
 3/13 Committee Executive Action--Bill Concurred as Amended 4 0
 3/13 Committee Report--Bill Concurred as Amended
 3/16 2nd Reading Concurred 42 6
 3/17 3rd Reading Concurred 42 7

Returned to House with Amendments
 4/09 2nd Reading Senate Amendments Not Concurred 91 5
 4/10 Free Conference Committee Appointed
 4/13 Hearing
 4/13 Free Conference Committee Report Received
 4/19 2nd Reading Free Conference Committee Report Adopted 97 1
 4/20 3rd Reading Free Conference Committee Report Adopted 87 11

Senate
 4/12 Free Conference Committee Appointed
 4/13 Free Conference Committee Report Received
 4/14 2nd Reading Free Conference Committee Report Adopted 50 0
 4/15 3rd Reading Free Conference Committee Report Adopted 44 6

4/20 Sent to Enrolling
 4/21 Returned from Enrolling
 4/21 Signed by Speaker
 4/22 Signed by President
 4/23 Transmitted to Governor
 4/27 Signed by Governor
 4/29 Chapter Number Assigned
 Chapter Number 472
 Effective Date: 4/27/1999 - Sections 1-4, 31, 66 and 70-73
 Effective Date: 10/01/1999 - Sections 5-30, 32-34, 36-65 and 67-69
 Effective Date: 1/01/2000 - Section 35

HB 101 Introduced by Bookout-Reinicke *LC0199 Drafter: Maly*

Revise the Membership of the Board of Plumbers;...

By Request of Department of Environmental Quality & Department of Public Health and Human Services

12/18 Introduced
 12/23 Referred to Business and Labor
 1/04 1st Reading
 1/11 Hearing
 1/11 Committee Executive Action--Bill Passed 18 0
 1/11 Committee Report--Bill Passed
 1/12 2nd Reading Passed 93 7
 1/13 3rd Reading Passed 94 4

Transmitted to Senate
 1/27 Referred to Labor and Employment Relations
 3/02 Hearing

HOUSE BILL NO. 100
INTRODUCED BY SIMON B
BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING LAWS ADMINISTERED BY THE STATE AUDITOR; GENERALLY REVISING STATE SECURITY LAWS; GENERALLY REVISING STATE INSURANCE LAWS; DEFINING "SERVICE CONTRACT INSURANCE"; DEFINING "MECHANICAL BREAKDOWN INSURANCE"; DEFINING "PREPAID LEGAL PLAN"; PROVIDING FOR EXCLUSIONS FROM THE DEFINITION OF "PREPAID LEGAL PLAN"; AMENDING SECTIONS 30-10-103, 30-10-104, 30-10-105, 30-10-107, 30-10-115, 30-10-201, 30-10-210, 31-1-233, 33-1-411, 33-2-109, 33-2-502, 33-2-701, 33-2-806, 33-3-202, 33-3-307, 33-4-101, 33-4-203, 33-4-311, 33-4-313, 33-5-402, 33-10-102, 33-15-1107, 33-16-102, 33-16-104, 33-16-1001, 33-16-1021, 33-16-1022, 33-16-1024, 33-16-1026, 33-17-212, 33-17-236, 33-17-505, 33-17-507, 33-17-603, 33-17-1203, 33-18-301, 33-18-1006, 33-20-121, 33-20-1201, 33-22-101, 33-22-111, 33-22-140, 33-22-205, 33-22-307, 33-22-514, 33-22-523, 33-22-524, 33-22-703, 33-22-1803, 33-22-1809, 33-22-1811, 33-22-1813, 33-22-1815, 33-22-1816, 33-22-1819, 33-30-102, 33-30-107, 33-30-201, 33-31-111, 33-31-202, 33-31-211, 33-31-216, 33-31-301, 33-31-401, 39-8-207, AND 61-12-303, MCA; REPEALING SECTIONS 33-2-1311, 33-7-526, 33-22-801, 33-22-802, 33-22-803, 33-22-804, 33-22-805, 33-22-806, 33-22-811, 33-22-812, 33-22-813, 33-22-814, 33-22-815, AND 33-22-816, MCA; AND PROVIDING EFFECTIVE DATES."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 30-10-103, MCA, is amended to read:

"30-10-103. Definitions. When used in parts 1 through 3 of this chapter, unless the context requires otherwise, the following definitions apply:

(1) (a) "Broker-dealer" means any person engaged in the business of effecting transactions in securities for the account of others or for the person's own account.

(b) The term does not include:

(i) a salesperson, issuer, bank, savings institution, trust company, or insurance company; or

(ii) a person who does not have a place of business in this state if the person effects transactions

1 in this state exclusively with or through the issuers of the securities involved in the transactions, other
2 broker-dealers, or banks, savings institutions, trust companies, insurance companies, investment
3 companies as defined in the Investment Company Act of 1940, pension or profit-sharing trusts, or other
4 financial institutions or institutional buyers, whether acting for themselves or as trustee.

5 (2) "Commissioner" means the securities commissioner of this state.

6 (3) (a) "Commodity" means:

7 (i) any agricultural, grain, or livestock product or byproduct;

8 (ii) any metal or mineral, including a precious metal, or any gem or gem stone, whether
9 characterized as precious, semiprecious, or otherwise;

10 (iii) any fuel, whether liquid, gaseous, or otherwise;

11 (iv) foreign currency; and

12 (v) all other goods, articles, products, or items of any kind.

13 (b) Commodity does not include:

14 (i) a numismatic coin with a fair market value at least 15% higher than the value of the metal it
15 contains;

16 (ii) real property or any timber, agricultural, or livestock product grown or raised on real property
17 and offered and sold by the owner or lessee of the real property; or

18 (iii) any work of art offered or sold by an art dealer at public auction or offered or sold through
19 a private sale by the owner.

20 (4) "Commodity Exchange Act" means the federal statute of that name.

21 (5) "Commodity futures trading commission" means the independent regulatory agency
22 established by congress to administer the Commodity Exchange Act.

23 (6) (a) "Commodity investment contract" means any account, agreement, or contract for the
24 purchase or sale, primarily for speculation or investment purposes and not for use or consumption by the
25 offeree or purchaser, of one or more commodities, whether for immediate or subsequent delivery or
26 whether delivery is intended by the parties and whether characterized as a cash contract, deferred
27 shipment or deferred delivery contract, forward contract, futures contract, installment or margin contract,
28 leverage contract, or otherwise. Any commodity investment contract offered or sold, in the absence of
29 evidence to the contrary, is presumed to be offered or sold for speculation or investment purposes.

30 (b) A commodity investment contract does not include a contract or agreement that requires, and

under which the purchaser receives, within 28 calendar days after the payment in good funds of any portion of the purchase price, physical delivery of the total amount of each commodity to be purchased under the contract or agreement. The purchaser is not considered to have received physical delivery of the total amount of each commodity to be purchased under the contract or agreement when the commodity or commodities are held as collateral for a loan or are subject to a lien of any person when the loan or lien arises in connection with the purchase of each commodity or commodities.

(7) (a) "Commodity option" means any account, agreement, or contract giving a party to the account, agreement, or contract the right but not the obligation to purchase or sell one or more commodities or one or more commodity contracts, whether characterized as an option, privilege, indemnity, bid, offer, put, call, advance guaranty, decline guaranty, or otherwise.

(b) The term does not include an option traded on a national securities exchange registered with the U.S. securities and exchange commission.

(8) (a) "Federal covered adviser" means a person who is:

~~—(a) registered under section 203 of the Investment Advisers Act of 1940; or,~~

~~(b) excluded from the definition of "investment adviser" under section 202(a)(11) of the Investment Advisers Act of 1940~~ The term does not include a person who would be exempt from the definition of investment adviser pursuant to subsection (11)(c)(i), (11)(c)(ii), (11)(c)(iii), (11)(c)(iv), (11)(c)(v), (11)(c)(vi), (11)(c)(vii), or (11)(c)(ix).

(9) "Federal covered security" means a security that is a covered security under section 18(b) of the Securities Act of 1933 or rules promulgated by the commissioner.

(10) "Guaranteed" means guaranteed as to payment of principal, interest, or dividends.

(11) (a) "Investment adviser" means a person who, for compensation, engages in the business of advising others, either directly or through publications or writings, as to the value of securities or as to the advisability of investing in, purchasing, or selling securities or who, for compensation and as a part of a regular business, issues or promulgates analyses or reports concerning securities.

(b) The term includes a financial planner or other person who:

(i) as an integral component of other financially related services, provides the investment advisory services described in subsection (11)(a) to others for compensation, as part of a business; or

(ii) represents to any person that the financial planner or other person provides the investment advisory services described in subsection (11)(a) to others for compensation.

(c) Investment adviser does not include:

(i) an investment adviser representative;

(ii) a bank, savings institution, trust company, or insurance company;

(iii) a lawyer or accountant whose performance of these services is solely incidental to the practice of the person's profession or who does not accept or receive, directly or indirectly, any commission, payment, referral, or other remuneration as a result of the purchase or sale of securities by a client, does not recommend the purchase or sale of specific securities, and does not have custody of client funds or securities for investment purposes;

(iv) a registered broker-dealer whose performance of services described in subsection (11)(a) is solely incidental to the conduct of business and for which the broker-dealer does not receive special compensation;

(v) a publisher of any newspaper, news column, newsletter, news magazine, or business or financial publication or service, whether communicated in hard copy form or by electronic means or otherwise, that does not consist of the rendering of advice on the basis of the specific investment situation of each client;

(vi) a person whose advice, analyses, or reports relate only to securities exempted by 30-10-104(1);

(vii) an engineer or teacher whose performance of the services described in subsection (11)(a) is solely incidental to the practice of the person's profession;

(viii) a federal covered adviser; or

(ix) other persons not within the intent of this subsection (11) as the commissioner may by rule or order designate.

(12) (a) "Investment adviser representative" means:

(i) any partner of, officer of, director of, or a person occupying a similar status or performing similar functions, or other individual, except clerical or ministerial personnel, employed by or associated with an investment adviser who:

~~##~~(A) makes any recommendation or otherwise renders advice regarding securities to clients;

~~###~~(B) manages accounts or portfolios of clients;

~~####~~(C) solicits, offers, or negotiates for the sale or sells investment advisory services; or

~~+++~~(D) supervises employees who perform any of the foregoing; and

1 (ii) with respect to a federal covered adviser, any person who is an investment adviser
2 representative with a place of business in this state as those terms are defined by the securities and
3 exchange commission under the Investment Advisers Act of 1940.

4 (b) ~~Investment adviser representative~~ The term does not include a salesperson registered pursuant
5 to 30-10-201(1) whose performance of the services described in subsection (12)(a) is solely incidental
6 to the conduct of business as a salesperson and for which the salesperson does not receive special
7 compensation other than fees relating to the solicitation or offering of investment advisory services of a
8 registered investment adviser or of a federal covered adviser who has made a notice filing under parts 1
9 through 3 of this chapter.

10 (13) "Issuer" means any person who issues or proposes to issue any security, except that with
11 respect to certificates of deposit, voting-trust certificates, or collateral-trust certificates or with respect
12 to certificates of interest or shares in an unincorporated investment trust not having a board of directors,
13 or persons performing similar functions, or of the fixed, restricted management, or unit type, the term
14 "issuer" means the person or persons performing the acts and assuming the duties of depositor or
15 manager pursuant to the provisions of the trust or other agreement or instrument under which the security
16 is issued.

17 (14) "Nonissuer" means not directly or indirectly for the benefit of the issuer.

18 (15) "Offer" or "offer to sell" includes each attempt or offer to dispose of or solicitation of an offer
19 to buy a security or interest in a security for value.

20 (16) "Person", for the purpose of parts 1 through 3 of this chapter, means an individual, a
21 corporation, a partnership, an association, a joint-stock company, a trust in which the interests of the
22 beneficiaries are evidenced by a security, an unincorporated organization, a government, or a political
23 subdivision of a government.

24 (17) "Precious metal" means the following, in coin, bullion, or other form:

25 (a) silver;

26 (b) gold;

27 (c) platinum;

28 (d) palladium;

29 (e) copper; and

30 (f) other items as the commissioner may by rule or order specify.

1 (18) "Registered broker-dealer" means a broker-dealer registered pursuant to 30-10-201.

2 (19) "Sale" or "sell" includes each contract of sale of, contract to sell, or disposition of a security
3 or interest in a security for value.

4 (20) "Salesperson" means an individual other than a broker-dealer who represents a broker-dealer
5 or issuer in effecting or attempting to effect sales of securities. A partner, officer, or director of a
6 broker-dealer or issuer is a salesperson only if the person otherwise comes within this definition.
7 Salesperson does not include an individual who represents:

8 (a) an issuer in:

9 (i) effecting a transaction in a security exempted by 30-10-104(1), (2), (3), (8), (9), (10), or (11);

10 (ii) effecting transactions exempted by 30-10-105, except when registration as a salesperson,
11 pursuant to 30-10-201, is required by 30-10-105 or by any rule promulgated under 30-10-105;

12 (iii) effecting transactions in a federal covered security described in section 18(b)(4)(D) of the
13 Securities Act of 1933 for a qualified purchaser as defined in section 18(b)(3) of the Securities Act of
14 1933; or

15 (iv) effecting transactions with existing employees, partners, or directors of the issuer if no
16 commission or other remuneration is paid or given directly or indirectly for soliciting any person in this
17 state; or

18 (b) a broker-dealer in effecting in this state solely those transactions described in section 15(h)(2)
19 of the Securities Exchange Act of 1934.

20 (21) "Securities Act of 1933", "Securities Exchange Act of 1934", "Public Utility Holding
21 Company Act of 1935", "Investment Advisors Act of 1940", and "Investment Company Act of 1940"
22 mean the federal statutes of those names.

23 (22) (a) "Security" means any note; stock; treasury stock; bond; commodity investment contract;
24 commodity option; debenture; evidence of indebtedness; certificate of interest or participation in any
25 profit-sharing agreement; collateral-trust certificate; preorganization certificate or subscription;
26 transferable shares; investment contract; voting-trust certificate; certificate of deposit for a security;
27 certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of
28 production under a title or lease; or, in general, any interest or instrument commonly known as a security,
29 any put, call, straddle, option, or privilege on any security, certificate of deposit, or group or index of
30 securities, including any interest in a security or based on the value of a security, or any certificate of

1 interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or
2 right to subscribe to or purchase any of the foregoing.

3 (b) Security does not include an insurance or endowment policy or annuity contract under which
4 an insurance company promises to pay a fixed sum of money either in a lump sum or periodically for life
5 or some other specified period.

6 (23) "State" means any state, territory, or possession of the United States, as well as the District
7 of Columbia and Puerto Rico.

8 (24) "Transact", "transact business", or "transaction" includes the meanings of the terms "sale",
9 "sell", and "offer".

10
11 **Section 2. Section 30-10-104, MCA, is amended to read:**

12 **"30-10-104. Exempt securities. Sections 30-10-202 through 30-10-207 and 30-10-211 do not**
13 **apply to any of the following securities:**

14 (1) any security, including a revenue obligation, issued or guaranteed by the United States, any
15 state, any political subdivision of a state, or any agency or corporate or other instrumentality of one or
16 more of the foregoing; provided, however, 30-10-202 through 30-10-207 and 30-10-211 apply to a
17 security issued by any of the foregoing that is payable solely from payments to be received in respect of
18 property or money used under a lease, sale, or loan arrangement by or for a nongovernmental industrial
19 or commercial enterprise, unless the enterprise or any security of which it is the issuer is within any of
20 the exemptions enumerated in subsections (2) through (15) of this section;

21 (2) any security issued or guaranteed by Canada, a Canadian province, a political subdivision of
22 a province, or an agency or corporate or other instrumentality of one or more of the foregoing or any other
23 foreign government with which the United States currently maintains diplomatic relations if the security
24 is recognized as a valid obligation by the issuer or guarantor;

25 (3) any security issued by and representing an interest in or a debt of or guaranteed by a bank
26 organized under the laws of the United States or a bank, savings institution, or trust company organized
27 and supervised under the laws of any state;

28 (4) any security issued by and representing an interest in, or a debt of, or guaranteed by a federal
29 savings and loan association or a building and loan or similar association organized under the laws of any
30 state and authorized to do business in this state;

1 (5) any security issued or guaranteed by a federal credit union or a credit union, industrial loan
2 association, or similar association organized and supervised under the laws of this state;

3 (6) any security issued or guaranteed by a railroad, other common carrier, public utility, or holding
4 company ~~which~~ that is:

5 (a) subject to the jurisdiction of the interstate commerce commission;

6 (b) a registered holding company under the Public Utility Holding Company Act of 1935 or a
7 subsidiary of a registered holding company within the meaning of that act;

8 (c) regulated in respect of its rates and charges by a governmental authority of the United States
9 or any state or municipality; or

10 (d) regulated in respect to the issuance or guarantee of the security by a governmental authority
11 of the United States, any state, Canada, or any Canadian province; also equipment trust certificates in
12 respect to equipment conditionally sold or leased to a railroad or public utility if other securities issued by
13 the railroad or public utility would be exempt under this subsection;

14 (7) any security that meets all of the following conditions:

15 (a) if the issuer is not organized under the laws of the United States or a state, it has appointed
16 ~~a~~ duly an authorized agent in the United States for service of process and has set forth the name and
17 address of the agent in its prospectus;

18 (b) a class of the issuer's securities is required to be and is registered under section 12 of the
19 Securities Exchange Act of 1934 and has been registered for the 3 years immediately preceding the
20 offering date;

21 (c) the issuer or a significant subsidiary has not had a material default during the last 7 years, or
22 during the issuer's existence if that period is less than 7 years, in the payment of:

23 (i) principal, interest, dividend, or sinking fund installment on preferred stock or indebtedness for
24 borrowed money; or

25 (ii) rentals under leases with terms of 3 years or more;

26 (d) the issuer has had consolidated net income, before extraordinary items and the cumulative
27 effect of accounting changes, of at least \$1 million in 4 of its last 5 fiscal years, including its last fiscal
28 year; and if the offering is of interest-bearing securities, has had for its last fiscal year such net income,
29 but before deduction for income taxes and depreciation, of at least 1 1/2 times the issuer's annual interest
30 expense, giving effect to the proposed offering and the intended use of the proceeds. "Last fiscal year",

as used in this subsection (7)(d), means the most recent year for which audited financial statements are available, provided that the statements cover a fiscal period ended not more than 15 months from the commencement of the offering.

(e) if the offering is of stock or shares, other than preferred stock or shares, the securities have voting rights and rights including the right to have at least as many votes per share and the right to vote on at least as many general corporate decisions as each of the issuer's outstanding classes of stock or shares, except as otherwise required by law;

(f) if the offering is of stock or shares, other than preferred stock or shares, the securities are owned beneficially or of record on any date within 6 months prior to the commencement of the offering by at least 1,200 persons and on that date there are at least 750,000 of the shares outstanding with an aggregate market value, based on the average bid price for that day, of at least \$3,750,000. In connection with the determination of the number of persons who are beneficial owners of the stock or shares of an issuer, the issuer or broker-dealer may rely in good faith for the purposes of this section upon written information furnished by the record owners.

(8) any security issued by any person organized and operated not for private profit but exclusively for religious, educational, benevolent, charitable, fraternal, social, athletic, or reformatory purposes if the issuer pays a fee of \$50 and files with the commissioner 20 days prior to the offering a written notice specifying the terms of the offer and the commissioner does not disallow the exemption in writing within the 20-day period;

(9) any commercial paper that arises out of a current transaction or the proceeds of which have been or are to be used for the current transaction and that evidences an obligation to pay cash within 9 months of the date of issuance, exclusive of days of grace, or any renewal of the paper ~~which~~ that is likewise limited or any guarantee of the paper or of any renewal, when the commercial paper is sold to banks or insurance companies;

(10) any investment contract issued in connection with an employee's stock purchase, savings, pension, profit-sharing, or similar benefit plan;

(11) any security for which the commissioner determines by order that an exemption would better serve the purposes of 30-10-102 than would registration. The fee for this exemption must be as prescribed in 30-10-209(4).

(12) any security listed or approved for listing upon notice of issuance on the New York stock

exchange, the American stock exchange, the Pacific stock exchange, the Midwest stock exchange, the Chicago board of options exchange, the Philadelphia stock exchange, the Boston stock exchange, or any other stock exchange registered with the federal securities and exchange commission and approved by the commissioner; any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the foregoing. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(13) any national market system security listed or approved for listing upon notice of issuance on the national association of securities dealers automated quotation system or any other national quotation system approved by the commissioner; any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the securities listed in this subsection. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(14) any security issued by and representing an interest in, or a debt of, or any security guaranteed by any insurer organized and authorized to transact business under the laws of any state;

(15) any security for which an offer or sale is not directed to or received by a person in this state, and the issuer does not maintain a place of business in the state."

Section 3. Section 30-10-105, MCA, is amended to read:

"30-10-105. Exempt transactions -- rulemaking. Except as expressly provided in this section, 30-10-201 through 30-10-207 and 30-10-211 do not apply to the following transactions:

(1) a nonissuer isolated transaction, whether effected through a broker-dealer or not. A transaction is presumed to be isolated if it is one of not more than three transactions during the prior 12-month period.

(2) (a) a nonissuer distribution of an outstanding security by a broker-dealer registered pursuant to 30-10-201 if:

(i) quotations for the securities to be offered or sold (or the securities issuable upon exercise of any warrant or right to purchase or subscribe to the securities) are reported by the automated quotations system operated by the national association of securities dealers, inc., ~~(NASDAQ)~~ or by any other

1 quotation system approved by the commissioner by rule; or

2 (ii) the security has a fixed maturity or a fixed interest or dividend provision and there has been
3 no default during the current fiscal year or within the 3 preceding fiscal years or if the issuer and any
4 predecessors have been in existence for less than 3 years and there has been no default in the payment
5 of principal, interest, or dividends on the security.

6 (b) The commissioner may by order deny or revoke the exemption specified in subsection (2)(a)
7 with respect to a specific security. Upon the entry of an order, the commissioner shall promptly notify
8 all registered broker-dealers that it has been entered and give the reasons for the order and shall notify
9 them that within 15 days of the receipt of a written request, the matter will be set for hearing. If a
10 hearing is not requested and is not ordered by the commissioner, the order remains in effect until it is
11 modified or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after
12 notice of and opportunity for hearing to all interested persons, may modify or vacate the order or extend
13 it until final determination. An order under this subsection may not operate retroactively. A person may
14 not be considered to have violated parts 1 through 3 of this chapter by reason of any offer or sale
15 effected after the entry of an order under this subsection if the person sustains the burden of proof that
16 the person did not know and in the exercise of reasonable care could not have known of the order.

17 (3) a nonissuer transaction effected by or through a registered broker-dealer pursuant to an
18 unsolicited order or offer to buy, but the commissioner may require that the customer acknowledge upon
19 a specified form that the sale was unsolicited and that a signed copy of each form be preserved by the
20 broker-dealer for a specified period;

21 (4) a transaction between the issuer or other person on whose behalf the offering is made and
22 an underwriter or between underwriters;

23 (5) a transaction by an executor, administrator, sheriff, marshal, receiver, trustee in bankruptcy,
24 guardian, or conservator in the performance of official duties;

25 (6) a transaction executed by a bona fide pledgee without any purpose of evading parts 1 through
26 3 of this chapter;

27 (7) an offer or sale to a bank, savings institution, trust company, insurance company, investment
28 company as defined in the Investment Company Act of 1940, pension or profit-sharing trust, or other
29 financial institution or institutional buyer or to a broker-dealer, whether the purchaser is acting for itself
30 or in a fiduciary capacity;

1 (8) (a) a transaction pursuant to an offer made in this state directed by the offeror to not more
2 than 10 persons (other than those designated in subsection (7)) during any period of 12 consecutive
3 months, if:

4 (i) the seller reasonably believes that all the buyers are purchasing for investment; and

5 (ii) a commission or other remuneration is not paid or given directly or indirectly for soliciting a
6 prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if the
7 securities involved are registered with the United States securities and exchange commission under the
8 federal Securities Act of 1933, as amended;

9 (b) any transaction pursuant to an offer made in this state directed by the offeror to not more
10 than 25 persons, other than those designated in subsection (7), during any period of 12 consecutive
11 months if:

12 (i) the seller reasonably believes that all the buyers are purchasing for investment;

13 (ii) a commission or other remuneration is not paid or given directly or indirectly for soliciting ~~any~~
14 a prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if
15 the securities involved are registered with the United States securities and exchange commission under
16 the federal Securities Act of 1933, as amended; and

17 (iii) the offeror applies for and obtains the written approval of the commissioner prior to making
18 any offers in this state and pays a filing fee that must accompany the application for approval. The
19 commissioner may deny an application.

20 (c) For the purpose of the exemptions provided for in this subsection (8), an offer to sell is made
21 in this state, whether or not the offeror or any of the offerees is then present in this state, if the offer
22 either originates from this state or is directed by the offeror to this state and received at the place to
23 which it is directed (or at any post office in this state in the case of a mailed offer).

24 (9) an offer or sale of a preorganization certificate or subscription if:

25 (a) a commission or other remuneration is not paid or given directly or indirectly for soliciting a
26 prospective subscriber;

27 (b) the number of subscribers does not exceed 25; and

28 (c) a payment is not made by a subscriber;

29 (10) a transaction pursuant to an offer to existing security holders of the issuer, including persons
30 who at the time of the transaction are holders of convertible securities, nontransferable warrants, or

1 transferable warrants exercisable within not more than 90 days of their issuance, if:

2 (a) a commission or other remuneration (other than a standby commission) is not paid or given
3 directly or indirectly for soliciting any security holder in this state; or

4 (b) the issuer first files a notice specifying the terms of the offer and the commissioner does not
5 by order disallow either subsection (10)(a) or the notice specifying the terms of the offer;

6 (11) an offer, but not a sale, of a security for which registration statements have been filed under
7 both parts 1 through 3 of this chapter and the Securities Act of 1933 if a stop, refusal, denial,
8 suspension, or revocation order is not in effect and a public proceeding or examination looking toward an
9 order is not pending under either law;

10 (12) an offer, but not a sale, of a security for which a registration statement has been filed under
11 parts 1 through 3 of this chapter and the commissioner does not disallow the offer in writing within 10
12 days of the filing;

13 (13) the issuance of a stock security dividend, whether the corporation distributing the dividend
14 is the issuer of the stock security or not, if nothing of value is given by ~~stockholders~~ security holders for
15 the distribution other than the surrender of a right to a cash dividend when the ~~stockholder~~ security holder
16 can elect to take a dividend in cash or stock in securities;

17 (14) a transaction incident to a right of conversion, ~~or~~ a statutory or judicially approved
18 reclassification, or a recapitalization, reorganization, quasi-reorganization, stock split, reverse stock split,
19 merger, consolidation, or sale of assets;

20 (15) a transaction in compliance with rules that the commissioner may adopt to serve the
21 purposes of 30-10-102. The commissioner may require that 30-10-201 through 30-10-207 and 30-10-211
22 apply to any ~~or all~~ transactional exemptions adopted by rule.

23 (16) a transaction in the securities of a certified Montana capital company or a certified Montana
24 small business investment capital company, as defined in 90-8-104, ~~provided that if~~ the company first
25 files all disclosure documents, along with a consent to service of process, with the commissioner. The
26 commissioner may not charge a fee for the filing.

27 (17) the sale of a commodity investment contract traded on a commodities exchange recognized
28 by the commissioner at the time of sale;

29 (18) a transaction within the exclusive jurisdiction of the commodity futures trading commission
30 as granted under the Commodity Exchange Act;

1 (19) a transaction that:

2 (a) involves the purchase of one or more precious metals;

3 (b) requires, and under which the purchaser receives within 7 calendar days after payment in
4 good funds of any portion of the purchase price, physical delivery of the quantity of the precious metals
5 purchased. For the purposes of this subsection, physical delivery is considered to have occurred if, within
6 the 7-day period, the quantity of precious metals, whether in specifically segregated or fungible bulk,
7 purchased by the payment is delivered into the possession of a depository, other than the seller, that:

8 (i) (A) is a financial institution, meaning a bank, savings institution, or trust company organized
9 under or supervised pursuant to the laws of the United States or of this state;

10 (B) is a depository the warehouse receipts of which are recognized for delivery purposes for any
11 commodity on a contract market designated by the commodity futures trading commission; or

12 (C) is a storage facility licensed by the United States or any agency of the United States; and

13 (ii) issues, and the purchaser receives, a certificate, document of title, confirmation, or other
14 instrument evidencing that the quantity of precious metals has been delivered to the depository and is
15 being and will continue to be held on the purchaser's behalf, free and clear of all liens and encumbrances
16 other than:

17 (A) liens of the purchaser;

18 (B) tax liens;

19 (C) liens agreed to by the purchaser; or

20 (D) liens of the depository for fees and expenses that previously have been disclosed to the
21 purchaser.

22 (c) requires the quantity of precious metals purchased and delivered into the possession of a
23 depository, as provided in subsection (19)(b), to be physically located within Montana at all times after
24 the 7-day delivery period provided in subsection (19)(b), and the precious metals are in fact physically
25 located within Montana at all times after that delivery period;

26 (20) a transaction involving a commodity investment contract solely between persons engaged
27 in producing, processing, using commercially, or handling as merchants each commodity subject to the
28 contract or any byproduct of the commodity;

29 (21) an offer or sale of a security to an employee of the issuer, pursuant to an employee stock
30 ownership plan qualified under section 401 of the Internal Revenue Code; or

1 (22) (a) an offer or sale of securities by a cooperative association organized under the provisions
2 of Title 35, chapter 15, or under the laws of another state that are substantially the same as the
3 provisions of Title 35, chapter 15, if the offer and sale are only to members of the cooperative association
4 or the purchase of the securities is necessary or incidental to establishing membership in the cooperative
5 association;

6 (b) a cooperative organized under the laws of another state may not take advantage of the
7 exemption created by this subsection (22) unless, not less than 10 days before the issuance or delivery
8 of the securities, the cooperative has furnished the commissioner with a general written description of
9 the transaction and any other information the commissioner may require by rule or otherwise. The
10 commissioner shall promulgate rules establishing a list of states whose laws are considered substantially
11 the same as Title 35, chapter 15, for the purposes of this subsection (22)."

12
13 Section 4. Section 30-10-107, MCA, is amended to read:

14 "30-10-107. Administration. (1) The administration of the provisions of parts 1 through 3 of this
15 chapter must be under the general supervision and control of the state auditor, the ex officio securities
16 commissioner. The commissioner may, from time to time, make, amend, and rescind rules and forms as
17 necessary to carry out the provisions of parts 1 through 3 of this chapter. A rule or form may not be
18 adopted unless the commissioner finds that the action is necessary or appropriate in the public interest
19 or for the protection of investors and consistent with the purposes of the policy and provisions of parts
20 1 through 3 of this chapter. In prescribing rules and forms, the commissioner may cooperate with the
21 securities administrators of the other states and the securities and exchange commission with a view to
22 effectuating the policy of parts 1 through 3 of this chapter to achieve maximum uniformity in the form
23 and content of registration statements, applications, and reports ~~wherever~~ whenever practicable.

24 (2) It is unlawful for the commissioner or any of the commissioner's officers or employees to use
25 for personal benefit any information filed with or obtained by the commissioner and not made public. The
26 provisions of parts 1 through 3 of this chapter do not authorize the commissioner or any of the
27 commissioner's officers or employees to disclose any information or the fact that any investigation is
28 being made, except among themselves or when necessary or appropriate in a proceeding or investigation
29 under parts 1 through 3 of this chapter.

30 (3) The provisions of parts 1 through 3 of this chapter imposing liability do not apply to any act

1 done or omitted in good faith in conformity with any rule, form, or order of the commissioner,
2 notwithstanding that the rule or form may later be amended or rescinded or be determined by judicial or
3 other authority to be invalid for any reason.

4 (4) Every hearing in an administrative proceeding must be public unless the commissioner grants
5 a request joined in by all the respondents that the hearing be conducted privately.

6 (5) A document is filed when it is received by the commissioner. The commissioner shall keep
7 a register of all applications for registration and registration statements that are or have ever been
8 effective under parts 1 through 3 of this chapter and all denial, suspension, or revocation orders that have
9 ever been entered under parts 1 through 3 of this chapter. The register must be open for public
10 inspection. The information contained in or filed with any registration statement, application, or report
11 may be made available to the public under rules the commissioner prescribes.

12 (6) Upon request and at a reasonable charge, the commissioner shall furnish to any person
13 photostatic or other copies, certified if requested, of any entry in the register or any document that is a
14 matter of public record. In any proceeding or prosecution under parts 1 through 3 of this chapter, any
15 certified copy is prima facie evidence of the contents of the entry or document certified.

16 (7) To serve the purposes of 30-10-102, the commissioner may cooperate with the securities and
17 exchange commission, the commodity futures trading commission, the securities investor protection
18 corporation, the securities registration depository, any national securities exchange, or national securities
19 association registered under the Securities Exchange Act of 1934, any national or international
20 organization of securities officials or agencies, and any governmental agency, corporation, or body.

21 (8) Except as specifically provided in this title, an order or notice may be given to a person by
22 personal delivery or by mail addressed to that person at the person's last recorded principal place of
23 business on file at the commissioner's office. An order or notice that is mailed is considered to have been
24 given at the time it is mailed."
25

26 **Section 5. Section 30-10-115, MCA, is amended to read:**

27 **"30-10-115. Deposits to the general fund.** (1) All fees, ~~examination charges~~, and miscellaneous
28 charges received by the commissioner pursuant to parts 1 through 3 of this chapter, except for portfolio
29 registration fees described in 30-10-209(1)(d) and examination costs collected under 30-10-210, must
30 be deposited in the general fund.

(2) All portfolio registration fees collected under 30-10-209(1)(d) and examination costs collected under 30-10-210 must be deposited in the state special revenue account to the credit of the state auditor's office. The funds allocated by this section to the state special revenue account may only be used to defray the expenses of the state auditor's office in discharging its administrative and regulatory powers and duties in relation to portfolio registration and examinations. Any excess fees must be deposited in the general fund."

Section 6. Section 30-10-201, MCA, is amended to read:

"30-10-201. Registration and notice filing requirements of broker-dealers, salespersons, investment advisers, and investment adviser representatives. (1) It is unlawful for a person to transact business in this state as a broker-dealer or salesperson, except as provided in 30-10-105, unless the person is registered under parts 1 through 3 of this chapter.

(2) It is unlawful for a broker-dealer or issuer to employ a salesperson to represent the broker-dealer or issuer in this state, except in transactions exempt under 30-10-105, unless the salesperson is registered under parts 1 through 3 of this chapter.

(3) It is unlawful for ~~any~~ a person to transact business in this state as an investment adviser or as an investment adviser representative unless:

(a) the person is registered under parts 1 through 3 of this chapter;

(b) the person does not have a place of business in the state and the person's only clients in this state are:

(i) investment companies, as defined in the Investment Company Act of 1940, or insurance companies;

(ii) other investment advisers;

(iii) federal covered advisers;

(iv) broker-dealers;

(v) banks;

(vi) trust companies;

(vii) savings and loan associations;

(viii) employee benefit plans with assets of not less than \$1 million;

(ix) governmental agencies or instrumentalities, whether acting for themselves or as trustees with

1 investment control; or

2 (x) other institutional investors as designated by rule or order of the commissioner; or

3 (c) the person does not have a place of business in this state and during the preceding 12-month
4 period, the person has not had more than five clients who are residents of this state, other than those
5 clients specified in subsection (3)(b).

6 (4) Except for federal covered advisers whose only clients are clients listed in subsection (3)(b)
7 or (3)(c), it is unlawful for a federal covered adviser to conduct advisory business in this state unless the
8 federal covered adviser complies with the provisions of subsection (6)(b).

9 (5) (a) It is unlawful for a person required to be registered as an investment adviser under Title
10 30, chapter 10, parts 1 through 3, to employ an investment adviser representative unless the investment
11 adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through
12 3.

13 (b) It is unlawful for a federal covered adviser to employ, supervise, or associate with an
14 investment adviser representative who maintains a place of business in this state unless the investment
15 adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through
16 3.

17 (6) (a) A broker-dealer or a salesperson, acting as an agent for an issuer or as an agent for a
18 broker-dealer in the offer or sale of securities for an issuer, or an investment adviser or investment adviser
19 representative may apply for registration by filing an application in the form that the commissioner
20 prescribes and payment of the fee prescribed in 30-10-209.

21 (b) Except for a federal covered adviser whose only clients are those listed in subsection (3)(b)
22 or (3)(c), a federal covered adviser shall, prior to acting as a federal covered adviser in this state, ~~pay~~
23 submit a notice filing to the commissioner consisting of the fee prescribed in 30-10-209 and shall file with
24 ~~the commissioner~~ copies of any documents filed with the securities and exchange commission that the
25 commissioner requires by rule or order. A notice filing is effective upon its receipt by the commissioner.

26 (7) The application must contain whatever information the commissioner requires. A registration
27 application of a broker-dealer, salesperson, investment adviser, or investment adviser representative may
28 not be withdrawn before the commissioner approves or denies the registration, without the express
29 written consent of the commissioner.

30 (8) When the registration requirements are met, the commissioner shall make the registration

effective. An effective registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative may not be withdrawn or terminated without the express written consent of the commissioner.

(9) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or a notice filing by a federal covered adviser:

(a) is effective until December 31 following the registration or notice filing or any other time as the commissioner may by rule adopt; and

(b) may be renewed pursuant to subsection (11).

(10) (a) The registration of a salesperson is not effective during any period when the salesperson is not associated with an issuer or a registered broker-dealer specified in the application. When a salesperson begins or terminates a connection with an issuer or registered broker-dealer, the salesperson and the issuer or broker-dealer shall promptly notify the commissioner.

(b) The registration of an investment adviser representative is not effective during any period when the person is not associated with either an investment adviser registered under this act or a federal covered adviser with an effective notice filing and who is specified in the application. When an investment adviser representative begins or terminates a connection with an investment adviser, the investment adviser shall promptly notify the commissioner. When an investment adviser representative begins or terminates a connection with a federal covered adviser, the investment adviser representative shall promptly notify the commissioner.

(11) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or notice filing for a federal covered adviser may be renewed by filing, prior to the expiration of the registration or notice filing, an application containing information as the commissioner may require to indicate any material change in the information contained in the original application or any renewal application for registration or notice filing, and payment of the fee prescribed by 30-10-209. A broker-dealer who is not a member of ~~NASD~~ the national association of securities dealers, inc., is required to file a financial statement of the broker-dealer within 90 days of the end of the broker-dealer's fiscal year, except as provided in section 15 of the Securities Exchange Act of 1934. A registered broker-dealer or investment adviser may file an application for registration of a successor, to become effective upon approval of the commissioner.

(12) (a) Except as provided in section 15 of the Securities Exchange Act of 1934 in the case of

1 a broker-dealer and section 222 of the Investment Advisers Act of 1940 in the case of an investment
2 adviser, every registered broker-dealer and investment adviser shall make and keep accounts and other
3 records, except with respect to securities exempt under 30-10-104(1), as may be prescribed by the
4 commissioner by rule or order. All required records of an investment adviser must be preserved for the
5 period the commissioner prescribes by rule or order. All the records of a registered broker-dealer or
6 investment adviser are subject at any time or from time to time to reasonable periodic, special, or other
7 examinations, within or outside this state, by representatives of the commissioner, as the commissioner
8 considers necessary or appropriate in the public interest or for the protection of investors.

9 (b) The commissioner may require investment advisers who are registered or required to be
10 registered to furnish or disseminate certain information as necessary or appropriate in the public interest
11 or for the protection of investors and advisory clients.

12 (c) If information contained in any document filed with the commissioner is, or becomes,
13 inaccurate or incomplete in any material respect, the registrant or federal covered adviser ~~must~~ shall
14 promptly file a correcting amendment.

15 (13) The commissioner may by order deny, suspend, or revoke registration of any broker-dealer,
16 salesperson, investment adviser, or investment adviser representative if the commissioner finds that the
17 order is in the public interest and that the applicant or registrant or, in the case of a broker-dealer or
18 investment adviser, any partner, officer, director, person occupying a similar status or performing similar
19 functions, or person directly or indirectly controlling the broker-dealer or investment adviser:

20 (a) has filed an application for registration under this section that, as of its effective date or as
21 of any date after filing in the case of an order denying effectiveness, was incomplete in any material
22 respect or contained any statement that was, in the light of the circumstances under which it was made,
23 false or misleading with respect to any material fact;

24 (b) has willfully violated or willfully failed to comply with any provision of parts 1 through 3 of
25 this chapter or a predecessor law or any rule or order under parts 1 through 3 of this chapter or a
26 predecessor law;

27 (c) has been convicted of any misdemeanor involving a security or any aspect of the securities
28 business or any felony;

29 (d) is permanently or temporarily enjoined by any court of competent jurisdiction from engaging
30 in or continuing any conduct or practice involving any aspect of the securities business;

1 (e) is the subject of an order of the commissioner denying, suspending, or revoking registration
2 as a broker-dealer, salesperson, investment adviser, or investment adviser representative;

3 (f) is the subject of an adjudication or determination, within the past 5 years, by a securities or
4 commodities agency or administrator of another state or a court of competent jurisdiction, that the person
5 has violated the Securities Act of 1933, the Securities Exchange Act of 1934, the Investment Advisors
6 Act of 1940, the Investment Company Act of 1940, or the Commodity Exchange Act or the securities
7 or commodities law of any other state;

8 (g) has engaged in dishonest or unethical practices in the securities business;

9 (h) is insolvent, either in the sense that the person's liabilities exceed the person's assets or in
10 the sense that the person cannot meet obligations as they mature, but the commissioner may not enter
11 an order against a broker-dealer or investment adviser under this subsection (13) without a finding of
12 insolvency as to the broker-dealer or investment adviser;

13 (i) has not complied with a condition imposed by the commissioner under this section or is not
14 qualified on the basis of such factors as training, experience, or knowledge of the securities business;

15 (j) has failed to pay the proper filing fee, but the commissioner may enter only a denial order
16 under this subsection (13), and the commissioner shall vacate any order when the deficiency has been
17 corrected; or

18 (k) has failed to reasonably supervise the person's salespersons or employees or investment
19 adviser representatives or employees to ~~assure~~ ensure their compliance with this act.

20 (14) The commissioner may not institute a suspension or revocation proceeding on the basis of
21 a fact or transaction known to the commissioner when registration became effective unless the
22 proceeding is instituted within 30 days after the date on which the registration became effective.

23 (15) The commissioner may by order summarily postpone or suspend registration pending final
24 determination of any proceeding under this section.

25 (16) Upon the entry of the order under subsection (13), the commissioner shall promptly notify
26 the applicant or registrant, as well as the employer or prospective employer if the applicant or registrant
27 is a salesperson or investment adviser representative, that it has been entered and of the reasons for the
28 order and that if requested by the applicant or registrant within 15 days after the receipt of the
29 commissioner's notification, the matter will be promptly set for hearing. If a hearing is not requested
30 within 15 days and none is ordered by the commissioner, the order will remain in effect until it is modified

1 or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after notice of
2 and opportunity for hearing, may modify or vacate the order or extend it until final determination.

3 (17) If the commissioner finds that ~~any~~ a registrant or applicant for registration is no longer in
4 existence or has ceased to do business as a broker-dealer, salesperson, investment adviser, or investment
5 adviser representative or is subject to an adjudication of mental incompetence or to the control of a
6 committee, conservator, or guardian or cannot be located after reasonable search, the commissioner may
7 by order cancel the registration or application.

8 (18) The commissioner may, after suspending or revoking registration of any broker-dealer,
9 salesperson, investment adviser, or investment adviser representative, impose a fine not to exceed
10 \$5,000 upon the broker-dealer, salesperson, investment adviser, or investment adviser representative.
11 The fine is in addition to all other penalties imposed by the laws of this state and must be collected by
12 the commissioner in the name of the state of Montana and deposited in the general fund. Imposition of
13 any fine under this subsection is an order from which an appeal may be taken pursuant to 30-10-308. If
14 any broker-dealer, salesperson, investment adviser, or investment adviser representative fails to pay a fine
15 referred to in this subsection, the amount of the fine is a lien upon all of the assets and property of the
16 broker-dealer, salesperson, investment adviser, or investment adviser representative in this state and may
17 be recovered by suit by the commissioner and deposited in the general fund. Failure of a broker-dealer,
18 salesperson, investment adviser, or investment adviser representative to pay a fine also constitutes a
19 forfeiture of the right to do business in this state under parts 1 through 3 of this chapter.

20 (19) A sole proprietor registered as a broker-dealer or investment adviser who does not employ
21 other salespersons or investment adviser representatives, other than the sole proprietor, is not required
22 to register as both a broker-dealer and a salesperson or as an investment adviser and an investment
23 adviser representative if the sole proprietor meets the examination requirements established by the
24 commissioner by rule.

25 (20) A person who is subject to the provisions of this section and who has passed the general
26 securities principal's examination is not required to also pass the uniform investment adviser law
27 examination. The commissioner shall by rule provide for a form that a person who passes the general
28 securities principal's examination shall file with the commissioner as a verification of having passed the
29 examination unless the commissioner can verify electronically that the person has passed the exam."
30

Section 7. Section 30-10-210, MCA, is amended to read:

"30-10-210. Examination costs. (1) An issuer, broker-dealer, or investment adviser who is examined in connection with a registration under parts 1 through 3 of this chapter shall reimburse the commissioner or any of ~~his duty~~ the commissioner's authorized agents, officers, or employees for actual travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners, ~~as which are~~ necessarily incurred on account of the examination, upon presentation of a detailed account of ~~such the~~ charges and expenses by the commissioner or pursuant to ~~his~~ the commissioner's written authorization; however, ~~no~~ reimbursement of expenses may not be required for routine examinations performed in connection with an application for registration. ~~No A~~ person may not pay and ~~no an~~ examiner may not accept additional emolument on account of ~~such~~ an examination.

(2) The commissioner shall ~~pay to the state treasurer to the credit of the general fund all moneys received hereunder~~ deposit examination costs collected under this section in the special revenue account provided for in 30-10-115. The commissioner may give written authorization for payment of the examination costs referred to in subsection (1) by the person examined directly to the examiner.

(3) If an issuer, broker-dealer, or investment adviser fails to pay the charges and expenses referred to ~~above~~ in subsection (1), the ~~same shall~~ charges and expenses must be paid out of the funds of the commissioner in the same manner as other disbursements of ~~such those~~ funds. The amount ~~so~~ paid is a first lien upon all of the assets and property in this state of the issuer, broker-dealer, or investment adviser and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund. Failure of the issuer, broker-dealer, or investment adviser to pay the charges and expenses also works a forfeiture of ~~his or its~~ the right to do business in this state under parts 1 through 3 of this chapter."

Section 8. Section 31-1-233, MCA, is amended to read:

"31-1-233. Insurance. (1) The amount, if any, included for insurance that may be purchased by the holder of the contract may not exceed the applicable premiums chargeable in accordance with the rates filed with the insurance department of this state ~~where~~ when the rates are required by law to be approved by the insurance department.

(2) All insurance purchased by the holder of the contract must be written by an insurance company authorized to do business in this state ~~and must be countersigned by a duly licensed resident~~

~~insurance producer authorized to engage in the insurance business in this state.~~

(3) A buyer may be required to provide insurance on the goods at ~~his~~ the buyer's own cost for the protection of the seller or holder as well as the buyer, but the insurance is limited to insurance against substantial risk of loss, damage, or destruction of the goods.

(4) Any other insurance may be included in a retail installment transaction at the buyer's expense only if contracted for voluntarily by the buyer.

(5) If insurance for which an identified charge is made insures the life, safety, or health of the buyer or ~~his~~ the buyer's interest in the goods and is purchased by the holder, the holder shall within 30 days after the execution of the retail installment contract send or cause to be sent to the buyer a policy or policies or certificate or certificates of insurance, written by an insurance company authorized to do business in this state, clearly setting forth:

(a) the amount of the premium;

(b) the kind or kinds of insurance;

(c) the coverages; and

(d) if a policy, all the terms, exceptions, limitations, restrictions, and conditions of the contract or contracts of insurance or, if a certificate, a summary of the terms, exceptions, limitations, restrictions, and conditions.

(6) The ~~seller~~ holder may not decline existing insurance written by an insurance company authorized to do business in this state, and the buyer has the privilege of purchasing insurance from an insurance producer or broker of ~~his~~ the buyer's own selection and of selecting ~~his~~ the buyer's insurance company, ~~provided that if:~~

(a) the insurance company is acceptable to the holder, which acceptance may not be unreasonably or arbitrarily withheld; and

(b) the inclusion of the cost of the insurance premium in the retail installment contract when the buyer selects ~~his~~ the buyer's insurance producer, broker, or company is optional with the ~~seller~~ holder.

(7) If any insurance is canceled or the premium adjusted, any refund of the insurance premium received by the holder must be credited to the final maturing installment of the contract except to the extent applied toward payment for a similar insurance protecting the interests of the buyer and the holder or either of them."

Section 9. Section 33-1-411, MCA, is amended to read:

"33-1-411. Destruction of records -- hindrance of examination -- penalty. ~~Any~~ A director, officer, agent, or employee of ~~any~~ a company who for the purpose of hindering any examination conducted pursuant to this part destroys any books, records, or documents required to be kept by law shall be punished by a fine of ~~not more than \$1,000~~ as provided in 33-1-317. After notice and hearing in accordance with Title 33, chapter 1, part 7, the commissioner may revoke the certificate of authority of ~~such the~~ the company."

Section 10. Section 33-2-109, MCA, is amended to read:

"33-2-109. Capital or surplus funds required. (1) To qualify for authority to transact any one kind of insurance, as defined in 33-1-205 through 33-1-212, or combinations of kinds of insurance as shown below, an insurer shall possess and ~~thereafter~~ maintain unimpaired paid-in capital stock, ~~if a stock insurer~~, or surplus, ~~if a mutual or foreign reciprocal insurer~~, in an amount not less than ~~as~~ is applicable under the ~~schedule~~ schedules below; and shall possess when first ~~so~~ authorized ~~such~~ to transact insurance any additional funds as surplus as required under 33-2-110:

<u>(a)</u> Kind or kinds of insurance	Minimum capital or surplus required
Life	\$200,000
Disability	200,000
Life and disability	300,000
Credit life and disability	50,000
Property	400,000
Marine	400,000
Casualty	
All lines, except workers' compensation	400,000
All lines, including workers' compensation	600,000
Surety	500,000
Title	200,000
Multiple lines, two or more of <u>of</u> property, marine, casualty, or surety	800,000

(b) For insurers licensed on or after October 1, 1999:

Kinds or kinds of insurance	Minimum capital or surplus required
Life	\$ 600,000
Disability	500,000
Life and disability	750,000
Credit life and disability	150,000
Property	500,000
Marine	500,000
Casualty	
All lines, except workers' compensation	500,000
All lines, including workers' compensation	750,000
Surety	500,000
Title	500,000
Multiple lines, two or more of property, marine, casualty, or surety	1,000,000

(2) ~~As to surplus required~~ Surplus requirements for qualification to transact one or more kinds of insurance ~~and thereafter to be maintained, for~~ domestic mutual insurers ~~shall be~~ are governed by Title 33, chapter 3, and surplus requirements for domestic reciprocal insurers ~~shall be~~ are governed by Title 33, chapter 5.

(3) Capital and surplus requirements ~~shall~~ must be based upon all the kinds of insurance actually transacted or to be transacted by the insurer in any ~~and all~~ areas in which it operates, whether or not only a portion of ~~such~~ the kinds are to be transacted in this state.

(4) A life insurer may also grant annuities without additional capital or additional surplus.

(5) For a credit life and disability insurer that is not a resident domestic insurer as defined in 33-1-201 and 33-1-202, the capital or surplus required by this section is an amount equal to four times the minimum capital or surplus required for credit life and disability pursuant to subsection (1)."

Section 11. Section 33-2-502, MCA, is amended to read:

"33-2-502. Assets expressly not allowed. In addition to assets impliedly excluded by the

provisions of 33-2-501, the following expressly ~~shall~~ may not be allowed as assets in any determination of the financial condition of an insurer:

(1) goodwill, trade names, and other like intangible assets;

(2) advances to officers, ~~to~~ other than policy loans, whether secured or not, and advances to employees, insurance producers, and other persons on personal security only;

(3) stock ~~of such owned by the insurer, owned by it, or any equity therein in the stock, or loans secured thereby by the stock, or any proportionate interest in such the stock acquired or held through the ownership by such the insurer of an interest in another firm, corporation, or business unit;~~

(4) furniture, fixtures, ~~to~~ other than electronic data processing machines authorized under 33-2-501(11)}, furnishings, safes, vehicles, libraries, stationery, literature, and supplies, except:

(a) in the case of title insurers, ~~such~~ materials and plants ~~as~~ that the insurer is expressly authorized to invest in under 33-2-851; and

(b) in the case of any insurer, ~~such~~ personal property ~~as~~ that the insurer is permitted to hold pursuant to part 8 of this chapter, ~~or which that~~ is acquired through foreclosure of chattel mortgages acquired pursuant to 33-2-831, ~~or which that~~ is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office, and similar purposes;

(5) the amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value ~~thereof~~ of the investments as determined under this code title; and

(6) prepaid expenses."

Section 12. Section 33-2-701, MCA, is amended to read:

"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury. (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner. The statement must be completed in accordance with the annual statement instructions and the accounting

1 practices and procedures manual of the national association of insurance commissioners. The statement
2 must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves. The
3 statement must be verified by the oath of the insurer's president or ~~vice-president~~ vice president and
4 secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
5 The commissioner may waive the verification under oath.

6 (2) (a) Each domestic insurer shall file electronic ~~diskette~~ versions of its annual and quarterly
7 financial statements with the national association of insurance commissioners. The filing date for
8 submission of the annual statement ~~diskette~~ electronic filing is March 1. The ~~filing-dates~~ dates for the
9 submission of the quarterly statement diskettes electronic filings are as follows:

- 10 (i) the first ~~calendar~~ quarter filing is due May 15;
11 (ii) the second ~~calendar~~ quarter filing is due August 15; and
12 (iii) the third ~~calendar~~ quarter filing is due November 15.

13 (b) The commissioner may exempt insurers that operate only in Montana from these filing
14 requirements.

15 (3) The statement of an alien insurer must relate only to its transactions and affairs in the United
16 States unless the commissioner requires otherwise. If the commissioner requires a statement as to an
17 alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as
18 soon as reasonably possible. The statement must be verified by the insurer's United States manager or
19 other authorized officer.

20 (4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate
21 of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer
22 failing to file its annual statement when due or within an extension of time that the commissioner may
23 grant.

24 (5) ~~Any~~ A director, officer or insurance producer, or employee of ~~any~~ a company who subscribes
25 to, makes, or concurs in making or publishing ~~any~~ an annual statement or any other statement required
26 by law knowing that the statement contains any material statement ~~which~~ that is false shall be punished
27 by a fine of not more than \$1,000.

28 (6) At the time of filing, the insurer shall pay to the commissioner the fee for filing its statement
29 as prescribed in 33-2-708.

30 (7) The commissioner may impose a fine not to exceed \$100 a day for each day after March 1

1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed
2 a maximum of \$1,000."

3
4 **Section 13. Section 33-2-806, MCA, is amended to read:**

5 **"33-2-806. Diversification of investments. An insurer shall invest in or hold as admitted assets**
6 **categories of investments only within applicable limits as follows:**

7 (1) An insurer may not, except with the consent of the commissioner, have at any one time any
8 combination of investments in or loans upon the security of the obligations, property, or securities of any
9 one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction does
10 not apply as to general obligations of the United States of America or of any state or include policy loans
11 made under 33-2-825.

12 (2) An insurer may not invest in or hold at any one time more than 10% of the outstanding voting
13 stock of any corporation, except with the consent of the commissioner. This provision does not apply as
14 to stock of a wholly owned subsidiary of the insurer or to controlling stock of an insurer acquired under
15 33-2-821.

16 ~~(3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount~~
17 ~~than the minimum paid in capital stock required under this code of a domestic stock insurer transacting~~
18 ~~like kinds of insurance, only in cash and the securities provided for in 33-2-811(1), 33-2-812, and~~
19 ~~33-2-830.~~

20 ~~(4)~~(3) A life insurer shall also invest and keep invested its funds in an amount not less than the
21 reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in
22 cash, in securities, in both cash and securities, or in investments provided for in 33-2-531.

23 ~~(5)~~(4) Except with the commissioner's consent, an insurer may not have invested at any one time
24 more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations of
25 public utilities.

26 ~~(6)~~(5) Except with the commissioner's consent, an insurer may not invest and have invested at
27 any one time in aggregate amount more than 15% of its assets in all stocks provided for in 33-2-820 and
28 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes
29 of this provision must be based on the cost of the stocks to the insurer. This provision does not apply to
30 stock of a controlled or subsidiary insurance corporation or other corporations provided for in 33-2-821

1 and 33-2-822.

2 ~~(7)~~(6) Except with the commissioner's consent, an insurer may not have invested at any one time
3 more than 5% of its assets in securities allowed in 33-2-824. Money market funds, as defined by the
4 commissioner by rule, are exempt from the 5% limitation of this subsection.

5 ~~(8)~~(7) Except with the commissioner's consent, an insurer may not have invested at any one time
6 more than 10% of its assets in the class of securities described in 33-2-814, 33-2-819, and 33-2-823.

7 ~~(9)~~(8) Limits of investments in real estate must be as provided in 33-2-832. Other specific limits
8 apply as stated in the sections dealing with other respective kinds of investments."
9

10 Section 14. Section 33-3-202, MCA, is amended to read:

11 "33-3-202. Articles of incorporation -- filing and approval. (1) The incorporators of a proposed
12 domestic insurer shall deliver the ~~quadruplicate~~ triplicate originals of the articles of incorporation to the
13 commissioner, together with the filing fees ~~therefor~~ specified in 33-2-708. The commissioner shall
14 examine the proposed articles of incorporation. If the commissioner finds that the articles comply with
15 this chapter and are not in conflict with the constitution and laws of the United States or of this state,
16 ~~he the commissioner shall endorse his place an endorsement of approval upon each set of the articles;~~
17 ~~except that. However,~~ if the commissioner finds that the proposed insurer would not be eligible for a
18 certificate of authority under 33-2-112, ~~he the commissioner~~ shall refuse to approve the articles of
19 incorporation and shall return them to the proposed incorporators, together with a written statement of
20 the reasons for ~~such the~~ refusal. If approved ~~by him~~, the commissioner shall then forward the endorsed
21 articles of incorporation, ~~with his approval endorsed thereon,~~ to the incorporators. The incorporators shall
22 ~~forthwith~~ file one set of the articles of incorporation with the secretary of state, and one set certified by
23 the secretary of state with the commissioner, ~~bearing the certification of the secretary of state, and one~~
24 ~~set with the county clerk of the county wherein is to be located the corporation's principal place of~~
25 ~~business, and the.~~ The remaining set of articles ~~shall~~ must be made a part of the corporation's record.

26 (2) If the commissioner finds that the proposed articles of incorporation do not comply with law,
27 ~~he the commissioner~~ shall refuse to approve the ~~same~~ articles and shall return all sets of the proposed
28 articles of incorporation to the proposed incorporators, together with a written statement of the reasons
29 for ~~his the~~ refusal ~~to approve~~.

30 (3) The corporation ~~shall have~~ has legal existence as ~~such a corporation~~ upon the issuance of the

1 certificate of incorporation by the secretary of state and the completion of the filings filing with the
2 commissioner referred to required in subsection (1) above, but it ~~shall~~ the corporation may not transact
3 business as an insurer until it has qualified for and received from the commissioner a certificate of
4 authority as provided in this code title.

5 (4) A copy of the certificate of incorporation, duly certified by the secretary of state, ~~shall be~~ is
6 admissible in all the courts of this state as prima facie evidence of due proper incorporation."

7
8 Section 15. Section 33-3-307, MCA, is amended to read:

9 "33-3-307. Bond Bonding of officers and employees. (1) ~~The president, secretary, and treasurer~~
10 When acting in a fiduciary capacity, officers and employees of each mutual insurer or stock insurer shall
11 ~~each file with the commissioner and maintain in force so long as that individual is an officer~~ a fidelity bond
12 ~~in an amount set by the commissioner by rule and~~ issued by an authorized corporate surety in favor of
13 the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in
14 determining the bond amount. In lieu of individual bonds, officers and employees may be covered under
15 a blanket bond for the same respective amounts. The insurer shall file the blanket bond ~~must be filed~~ with
16 the commissioner.

17 (2) The insurer shall pay the premium for the bond ~~must be payable by the insurer~~.

18 (3) A bond is not subject to cancellation except upon written notice to both the insurer and the
19 commissioner, delivered not less than 30 days in advance of the effective date of the cancellation.

20 ~~(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers~~
21 ~~in any way responsible for the handling of the funds of the insurer.~~

22 ~~(5)(4)~~ This section may not be considered to limit the amount of bonded protection that the
23 insurer may carry as to any officer or employee.

24 (5) The commissioner may adopt rules to determine the bond amount for officers and employees
25 who are subject to the provisions of this section."

26
27 Section 16. Section 33-4-101, MCA, is amended to read:

28 "33-4-101. Scope of chapter -- provisions applicable. (1) The chapter applies to:

29 (a) all domestic mutual hail, fire, and other casualty insurers of farm property and stock and rural
30 buildings formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections

1 40-1501 through 40-1517 of the Revised Codes of Montana, 1947;

2 (b) all domestic mutual rural insurers formed and immediately prior to January 1, 1961, lawfully
3 transacting insurance under sections 40-1601 through 40-1625 of the Revised Codes of Montana, 1947;

4 (c) all insurers formed under this chapter.

5 (2) The insurance laws of this state do not apply to or govern, either directly or indirectly,
6 domestic farm mutual insurers except as ~~contained or referred to~~ provided in this chapter.

7 (3) The following chapters and sections of this title apply to farm mutual insurers to the extent
8 applicable and not inconsistent with the express provisions of this chapter and the reasonable implications
9 of the express provisions of this chapter: chapter 1, parts 1 through 4, ~~and 7, 12, and 13~~; 33-2-112;
10 33-2-501; 33-2-502; 33-2-532 through 33-2-535; 33-2-708; ~~chapter 2, parts 13 and 16~~; 33-2-1212;
11 chapter 2, parts 13 and 16; 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436;
12 and chapter 18."

13
14 **Section 17.** Section 33-4-203, MCA, is amended to read:

15 **"33-4-203. Approval of articles -- commencement of corporate existence.** (1) If the commissioner
16 finds the proposed articles of incorporation to be in accordance with the provisions of this chapter and
17 not in conflict with the constitution and laws of the United States ~~of America~~ or of this state, the
18 commissioner shall make a certificate of the facts.

19 (2) If the commissioner considers the name of the proposed corporation to be so similar to one
20 already appropriated by another company or corporation as to be likely to mislead the public, the
21 commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

22 (3) When the proposed articles of incorporation have been approved by the commissioner, the
23 commissioner shall endorse the approval upon each set of the articles and forward ~~four~~ three sets of
24 articles to the incorporators. The incorporators shall file, with the required filing fee, one of the sets of
25 articles with the secretary of state; and one set certified by the secretary of state with the commissioner
26 ~~bearing the certification of the secretary of state, and one set with the county clerk of the county in~~
27 ~~which the principal place of business of the corporation is located and shall pay to the secretary of state~~
28 ~~and the county clerk the customary filing fees.~~ The remaining set of articles must be made a part of the
29 corporation's records.

30 (4) The corporation has legal existence upon the approval of the articles by the commissioner and

1 completion of the filings ~~referred to~~ required in subsection (3), but it may not transact business as an
2 insurer until it has ~~fulfilled the requirements for and has~~ obtained a certificate of authority as provided in
3 33-4-505."

4
5 Section 18. Section 33-4-311, MCA, is amended to read:

6 "33-4-311. Bonds Bonding of officers, managers, and employees. (1) ~~The treasurer and secretary~~
7 ~~of an insurer~~ When acting in a fiduciary capacity, officers, managers, and employees shall each give bonds
8 to the insurer for the faithful performance of their duties; ~~in such amount as is designated by the board~~
9 ~~of directors. Any such~~ The bond shall must be one issued by an authorized corporate surety.

10 (2) The commissioner may adopt rules to determine the amount of the bonds required under this
11 section."

12
13 Section 19. Section 33-4-313, MCA, is amended to read:

14 "33-4-313. Annual statement. The president and secretary of each insurer, on or before March
15 1 each year, shall prepare, affirm under oath, ~~affix the corporate seal to,~~ and file with the commissioner,
16 on forms prescribed and furnished by the commissioner, an annual statement for the preceding calendar
17 year showing the condition of the insurer as of December 31 of the preceding year and exhibiting the
18 following facts:

- 19 (1) the names of the president and secretary;
20 (2) the date of the annual meeting;
21 (3) the amount of insurance in force;
22 (4) the number of members;
23 (5) the number of assessments made during the year;
24 (6) the amount paid in losses during the year;
25 ~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;~~
26 ~~(8)~~(7) the number of members withdrawn, suspended, and expelled during the year;
27 ~~(9)~~(8) the number of new members admitted during the year;
28 ~~(10)~~(9) the expenses during the year;
29 ~~(11)~~(10) the amount of money on hand;
30 ~~(12)~~(11) the amount and character of the insurer's assets;

1 ~~(13)~~(12) the amount of the insurer's liabilities, including any reserves required to be established
2 under this chapter; and
3 ~~(14)~~(13) other information concerning the insurer's affairs that the commissioner may reasonably
4 require."

5
6 **Section 20.** Section 33-5-402, MCA, is amended to read:

7 **"33-5-402. Contributions to insurer.** The attorney or other parties may advance to a domestic
8 reciprocal insurer upon reasonable terms funds that it may require from time to time in its operations.
9 Sums advanced may not be treated as a liability of the insurer. Except upon liquidation of the insurer,
10 during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed
11 the lesser of the ~~insured's~~ insurer's realized earned surplus or 10% of the sums advanced as of the
12 previous December 31. A withdrawal or repayment may not be made without the advance approval of
13 the commissioner. This section does not apply to bank loans or to loans for which security is given."

14
15 **Section 21.** Section 33-10-102, MCA, is amended to read:

16 **"33-10-102. Definitions.** As used in this part, the following definitions apply:

17 (1) "Association" means the Montana insurance guaranty association created under 33-10-103.

18 (2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, ~~which that~~
19 arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy
20 to which this part applies issued by an insurer, if ~~such~~ the insurer becomes an insolvent insurer after July
21 1, 1971, and:

22 (i) the claimant or insured is a resident of this state at the time of the insured event; or

23 (ii) the property from which the claim arises is permanently located in this state.

24 (b) ~~"Covered claim" shall~~ Covered claim does not include any amount: ~~due a reinsurer, insurer,~~
25 ~~insurance pool, or underwriting association, as subrogation recoveries or otherwise.~~

26 (i) awarded as punitive or exemplary damages;

27 (ii) sought as a return of premium under a retrospective rating plan; or

28 (iii) due a reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries,
29 reinsurance recoveries, contribution, or indemnification. If insolvent, a reinsurer, insurer, insurance pool,
30 or underwriting association may not assert a claim in any amount against an insured except to the extent

1 that the claim exceeds the policy limits of the insured's policy.

2 (3) "Insolvent insurer" means an insurer:

3 (a) authorized to transact insurance in this state either at the time the policy was issued or when
4 the insured event occurred; and

5 (b) determined to be insolvent by a court of competent jurisdiction.

6 (4) "Member insurer" means ~~any~~ a person who:

7 (a) writes any kind of insurance to which this part applies under 33-10-101(3), including the
8 exchange of reciprocal or interinsurance contracts; and

9 (b) is licensed to transact insurance in this state.

10 (5) (a) "Net direct written premiums" means direct gross premiums written in this state on
11 insurance policies to which this part applies, less return premiums ~~thereon~~ on the policies and dividends
12 paid or credited to policyholders ~~on such direct business~~ of policies to which this part applies.

13 (b) "Net Net direct written premiums" ~~premiums~~ does not include premiums on contracts between
14 insurers or reinsurers.

15 (6) "Person" means any individual, corporation, partnership, association, or voluntary
16 organization."

17
18 Section 22. Section 33-15-1107, MCA, is amended to read:

19 "33-15-1107. Information about grounds for nonrenewal. ~~(1) If an insured questions the facts~~
20 ~~upon which an insurer's decision to cancel or not renew is based, the insurer shall mail or deliver such~~
21 ~~information to the insured within 15 working days of receiving a written request from the insured. If the~~
22 insurer or insurance producer receives a written request from an insured within 90 business days from
23 the date on which the insurer mailed a notice of cancellation or nonrenewal to the insured, the insurer or
24 insurance producer shall, within 21 days of receiving the insured's written request, furnish the insured
25 the information that the insurer or insurance producer used to make its decision. A notice is not effective
26 unless it contains adequate information about the insured's right to make the request.

27 (2) This section does not apply if the ground for cancellation or nonrenewal is nonpayment of the
28 premium and the reason is stated in the notice ~~so states.~~"

29
30 Section 23. Section 33-16-102, MCA, is amended to read:

1 **"33-16-102. Definitions.** In this chapter, the following definitions apply:

2 (1) "Advisory organization" means ~~every~~ each person, other than an admitted insurer, whether
3 located within or outside this state, who prepares policy forms or makes underwriting rules incident to
4 but not including the making of rates, rating plans, or rating systems or ~~which~~ who collects and furnishes
5 to admitted insurers or rating organizations loss or expense statistics or other statistical information and
6 data and acts in an advisory, as distinguished from a ratemaking, capacity. ~~No duly authorized~~ A licensed
7 attorney ~~at law~~, acting in the usual course of ~~his~~ the profession, ~~shall~~ may not be ~~deemed to be~~
8 considered an advisory organization.

9 (2) "Dividend" means:

10 (a) a noncontractual and nonrecoverable payment or credit declared by an insurer's board of
11 directors and paid out or credited out of earned surplus to policyholders, members, or subscribers; or

12 (b) in the absence of earned surplus, a noncontractual and nonrecoverable payment or credit
13 declared by an insurer's board of directors and paid to policyholders, members, or subscribers with the
14 written permission of the commissioner. The commissioner may grant permission only if the payment of
15 the dividend or credit will not reduce the insurer's capital below an amount three times the minimum
16 capital required under 33-2-109.

17 ~~(2)(3)~~ (3) "Member" means an insurer who participates in or is entitled to participate in the
18 management of a rating, advisory, or other organization.

19 ~~(3)(4)~~ (4) "Rating organization" means ~~every~~ each person, other than an admitted insurer, whether
20 located within or outside this state, ~~who has as his~~ with the object or purpose ~~the~~ of making of rates,
21 rating plans, or rating systems. Two or more admitted insurers ~~which~~ who act in concert for the purpose
22 of making rates, rating plans, or rating systems and ~~which~~ who do not operate within the specific
23 authorizations contained in 33-16-105, 33-16-302, 33-16-304, 33-16-305, and 33-16-307 ~~shall~~ must be
24 ~~deemed to be~~ considered a rating organization. ~~No~~ A single insurer ~~shall~~ may not be ~~deemed to be~~
25 considered a rating organization.

26 ~~(4)(5)~~ (5) "Subscriber" means an insurer ~~which~~ who is furnished at its request with rates and rating
27 manuals by a rating organization of which ~~it~~ the insurer is not a member or with advisory services by an
28 advisory organization of which it is not a member.

29 ~~(5)(6)~~ (6) "Willful" or "willfully", in relation to an act or omission ~~which~~ that constitutes a violation
30 of this chapter, means with actual knowledge or belief that ~~such~~ the act or omission constitutes ~~such a~~

1 violation and with specific intent to commit ~~such~~ the violation."

2
3 Section 24. Section 33-16-104, MCA, is amended to read:

4 "33-16-104. Payment of dividends, savings, or unabsorbed premium deposits not prohibited or
5 regulated -- plan for payment not rating system. Nothing in this chapter ~~shall~~ may be construed to prohibit
6 or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by
7 insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or
8 unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or
9 subscribers ~~shall~~ may not be ~~deemed considered~~ a rating plan or system. A plan for the payment of
10 dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders,
11 members, or subscribers does not relieve the insurer from complying with any requirements of this chapter
12 regarding rating plans or systems."

13
14 Section 25. Section 33-16-1001, MCA, is amended to read:

15 "33-16-1001. Declaration of policy and purpose. (1) It is declared that the public welfare is served
16 by the making of advisory premium rates for workers' compensation insurance coverage in concert.

17 (2) It is the purpose of this part to:

18 (a) authorize ~~such~~ ratemaking in concert and the operating of rating advisory organizations
19 thereto; and

20 (b) establish the general bases and standards for ~~the making of such~~ rates."

21
22 Section 26. Section 33-16-1021, MCA, is amended to read:

23 "33-16-1021. Ratemaking standards -- review by commissioner. (1) Rates may not be excessive,
24 inadequate, or unfairly discriminatory.

25 (2) Rates in a competitive market are not excessive. Rates in a noncompetitive market are
26 excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services
27 rendered.

28 (3) A rate may not be determined to be inadequate unless:

29 (a) it is clearly insufficient to sustain projected losses and expenses; and

30 (b) the rate is unreasonably low and the use of the rate by the insurer has had or, if continued,

1 will tend to create a monopoly in the market; or

2 (c) funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are
3 not produced when prospective loss costs are applied to anticipated payrolls.

4 (4) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to
5 reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory
6 because different premiums result for policyholders with different loss exposures or expense levels.

7 (5) In determining whether rates comply with standards under subsection (1), consideration must
8 be given to:

9 (a) past and prospective loss experience within and outside Montana, in accordance with
10 accepted actuarial principles;

11 (b) catastrophe hazards and contingencies;

12 (c) past and prospective expenses within and outside Montana;

13 (d) loadings for leveling premium rates over time for dividends, savings, or unabsorbed premium
14 deposits allowed or returned by insurers to their policyholders, members, or subscribers;

15 (e) a reasonable margin for underwriting profit; and

16 (f) all other relevant factors within and outside Montana.

17 (6) The systems of expense provisions included in the rates for use by an insurer or group of
18 insurers may differ from those of any other insurer or group of insurers to reflect the requirements of the
19 operating methods of the insurer or group of insurers.

20 (7) The rate may contain provisions of contingencies and an allowance permitting a reasonable
21 profit. In determining the reasonableness of a profit, consideration must be given to all investment income
22 attributable to premiums and the reserves associated with those premiums.

23 (8) The commissioner may investigate and determine whether rates in Montana are excessive,
24 inadequate, or unfairly discriminatory. In any investigation and determination, the commissioner shall also
25 consider the factors specified in 33-16-1020."

26
27 **Section 27. Section 33-16-1022, MCA, is amended to read:**

28 **"33-16-1022. Dividends -- ~~no~~ regulation or prohibition.** (1) An advisory organization may not adopt
29 a rule that would regulate or prohibit the payment of dividends, savings, or unabsorbed premium deposits
30 allowed or returned by insurers to their policyholders, members, or subscribers.

u

(2) A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers is not a rating plan or system. A plan for the payment of dividends, savings, or unabsorbed premium deposits does not relieve an insurer from complying with any requirement of this chapter regarding rating plans or systems.

(3) It is an unfair trade practice under 33-18-1003 to make the payment of a dividend or any portion of it conditioned upon renewal of the policy or contract."

Section 28. Section 33-16-1024, MCA, is amended to read:

"33-16-1024. Plan No. 3 membership in licensed workers' compensation advisory organization -- reporting requirements. (1) The plan No. 3 insurer under Title 39, chapter 71, part 23, is required to be a member of a licensed workers' compensation advisory organization ~~or a licensed workers' compensation rating organization~~ under Title 33, chapter 16, part 4.

(2) If the plan No. 3 insurer is not a member of the workers' compensation advisory organization designated under 33-16-1023, then, subject to the deviations from the uniform statistical plan, uniform classification system, and uniform experience rating plan that may be approved by the board of directors of the plan No. 3 insurer as provided in 39-71-2316, the insurer shall:

(a) record and report its workers' compensation experience to the designated advisory organization as required in the uniform statistical plan of the designated workers' compensation advisory organization approved by the commissioner, the uniform classification system, and the uniform experience rating plan that have been filed by the designated advisory organization with and approved by the commissioner; and

(b) use the forms and adhere to the rules that the designated advisory organization develops and files with the commissioner under 33-16-1023."

Section 29. Section 33-16-1026, MCA, is amended to read:

"33-16-1026. Rate filings. (1) A workers' compensation advisory organization shall file with the commissioner:

(a) workers' compensation rates and rating plans that are limited to prospective loss costs;

(b) each workers' compensation policy form to be used by its members or subscribers;

(c) the uniform classification plan and rules of the advisory organization;

42

(d) the uniform experience rating plan and rules of the advisory organization; and

(e) any other information that the commissioner requests and is entitled to receive under this part.

(2) Each insurer shall file with the commissioner all rates, supplementary rate information, and any changes and amendments made by it for use in this state as required by the commissioner under 33-16-1027(2).

(3) An insurer may establish rates and supplementary rate information based upon the factors in 33-16-1021. An insurer may adopt by reference, with or without deviation, the prospective loss costs filed by the advisory organization designated under 33-16-1023 ~~or the rates and supplementary rate information filed by another insurer.~~ An insurer may adopt by reference the rates and supplementary rate information filed by another insurer if both insurers belong to the same fleet of insurance companies, one insurer is acquiring the other insurer, or the insurers are merging.

(4) An insurer may not make or issue a contract or policy of insurance under this part, except in accordance with the filings that are in effect for the insurer as provided in this part.

(5) In addition to other prohibitions in this part, an advisory organization may not file rates, supplementary rate information, or supporting information on behalf of an insurer.

(6) If each rate in a schedule of workers' compensation rates for specific classifications of risks filed by an insurer is not lower than the prospective loss costs contained in the schedule of workers' compensation rates for those classifications filed by the designated advisory organization under subsection (1), the schedule of rates filed by the insurer is not subject to 33-16-1027(1) but becomes effective upon filing."

Section 30. Section 33-17-212, MCA, is amended to read:

"33-17-212. Examination required -- exceptions -- fees. (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by

33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) ~~If the applicant is a~~ A partnership or corporation, ~~each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination~~ shall name individuals on the partnership or corporation insurance producer's application. The named individuals shall take the examination and must be individually licensed for each kind of insurance that the individual can solicit as an insurance producer.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title insurance producer, as defined in 33-25-105;

- (c) an applicant for a license as a nonresident insurance producer;
- (d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that the applicant is qualified to sell the insurance;
- (e) transportation ticket agents of common carriers applying for a license to solicit and sell only:
- (i) accident insurance ticket policies; or
- (ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;
- (f) an association applying for a license under 33-17-211;
- (g) a mechanical breakdown insurance producer;
- (h) a service contract insurance producer; or
- (i) a prepaid legal plans producer; or
- ~~(j)~~ (i) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and that is not covered under the license held in the other state."

Section 31. Section 33-17-236, MCA, is amended to read:

"33-17-236. Appointments of insurance producers by insurers. (1) An insurance producer may not claim to be a representative of or an authorized or appointed insurance producer of or use another term implying a contractual relationship with a particular insurer and may not accept applications for the insurer unless the insurance producer becomes an appointed insurance producer of that insurer pursuant to this section. The following are the appointing insurer's requirements for making appointment of a licensed insurance producer:

(a) The insurer shall, ~~no~~ not later than 15 days from the date on which the agency contract is executed or the first insurance application is submitted by a licensed insurance producer, whichever is earlier, file with the insurance department a written notice of appointment on a form prescribed by the insurance department. The notice may be electronically filed pursuant to rules adopted by the

1 commissioner.

2 (b) If there is ~~no~~ not an executed agency contract, the insurer shall mail to the licensed insurance
3 producer, ~~no~~ not later than 15 days from the date on which the first insurance application is submitted
4 by ~~him~~ the licensed insurance producer, a copy of the notice of appointment form filed with the insurance
5 department. If the licensed insurance producer does not receive the acknowledgment of appointment from
6 the insurer within 30 days from the date on which the first insurance application is submitted to the
7 insurer, the insurance producer shall immediately discontinue acting as an insurance producer on behalf
8 of that insurer until the acknowledgment is received or the agency contract is executed.

9 (2) Upon receipt of the notice of appointment, the insurance department shall verify within 5
10 working days that the licensed insurance producer is eligible for appointment. If the licensed insurance
11 producer is determined to be ineligible for appointment, the insurance department shall notify the insurer
12 within 5 days of the determination.

13 (3) An appointment is effective on the earlier of the date of the executed contract and or the date
14 on which the insurer files the notice of appointment with the insurance department.

15 (4) The appointment is perpetual until canceled by the insurer or insurance producer."

16
17 Section 32. Section 33-17-505, MCA, is amended to read:

18 "33-17-505. Qualification -- fee. (1) In order to determine the competency of an applicant for a
19 consultant license, the commissioner shall require the applicant to pass an examination.

20 (2) The commissioner may conduct the examination or make arrangements, including contracting
21 with an outside testing service, for administering the examination and collecting the fees required by
22 33-17-503. The commissioner may arrange for the testing service to recover its cost of the examination
23 from the applicant.

24 ~~(2)(3)~~ The fee for taking the consultant license examination is \$50. The commissioner shall
25 deposit all fees collected in the general fund. The fee for taking a second or subsequent examination may
26 be no more than the cost of administering the examination, not to exceed \$50.

27 (4) (a) An applicant is not required to take an examination if the applicant has acquired the
28 required competency through the attainment of a recognized professional insurance designation.

29 (b) The commissioner may adopt rules specifying which professional insurance designations
30 demonstrate the required competency referred to in subsection (4)(a)."

1

2 **Section 33.** Section 33-17-507, MCA, is amended to read:

3 **"33-17-507. Revocation.** The commissioner may revoke or suspend a consultant license for a
4 specified period he determines if, after giving notice and conducting a hearing, as specified in this
5 chapter, he To revoke or suspend a license, the commissioner shall determines determine that the
6 licensee:

7 (1) has violated any provision of or any obligation imposed by the insurance law or has violated
8 any law in the course of ~~his dealings~~ dealing as an insurance consultant;

9 (2) has made a material misstatement in application for a consultant license;

10 (3) has been guilty of fraudulent or dishonest practices; or

11 (4) has demonstrated ~~his~~ incompetency or untrustworthiness to act as an insurance consultant."

12

13 **Section 34.** Section 33-17-603, MCA, is amended to read:

14 **"33-17-603. Certificate of registration.** (1) Except as provided in 33-17-604, a person may not
15 act as or represent to the public that the person is an administrator in this state unless the person holds
16 a certificate of registration as an administrator.

17 (2) An application for a certificate of registration must be accompanied by a fee of \$100. The
18 commissioner shall issue the certificate unless the commissioner finds that the applicant is not competent,
19 trustworthy, financially responsible, or of good personal and business reputation or that the applicant has
20 had a previous application for a license denied for cause within 5 years.

21 (3) A certificate of registration must be renewed each year by the administrator paying a
22 continuation fee of \$100 on or before July 1. Upon payment, the certificate continues in force unless
23 suspended, revoked, or otherwise terminated. The commissioner shall deposit the fee with the state
24 treasurer to be credited to the general fund.

25 (4) A certificate of registration may be suspended or revoked if, after notice and hearing, the
26 commissioner finds that the administrator has violated any of the requirements of this part or that the
27 administrator is not competent, trustworthy, financially responsible, or of good personal and business
28 reputation.

29 (5) Unless a certification requirement is waived, a person who acts as an administrator without
30 a certificate of registration is subject to a fine ~~of not less than \$500 or more than \$1,500.~~

1
2 **Section 35. Section 33-17-1203, MCA, is amended to read:**

3 **"33-17-1203. Continuing education -- basic requirements -- exceptions. (1) Unless exempt under**
4 **subsection (4):**

5 (a) a person licensed to act as an insurance producer for property, casualty, surety, or title
6 insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10
7 credit hours of approved continuing education;

8 (b) a person licensed to act as an insurance producer for life or disability insurance or as a
9 consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of
10 approved continuing education;

11 (c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit
12 hours of approved continuing education;

13 (d) a person licensed to act as an insurance producer only for credit life and disability insurance
14 shall, during each calendar year, complete 5 credit hours of approved continuing education in the areas
15 of insurance law, ethics, or credit life and disability insurance;

16 (e) a person licensed as an insurance producer or consultant shall, during each biennium, complete
17 at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and
18 administrative rules.

19 (2) If a person licensed as an insurance producer or consultant completes more credit hours of
20 approved continuing education in a year than the minimum required in subsection (1), the excess credit
21 hours may be carried forward and applied to the continuing education requirements of the next year.

22 (3) The commissioner may, for good cause, grant an extension of time, not to exceed 1 year,
23 during which the requirements imposed by subsection (1) may be completed.

24 (4) The minimum continuing education requirements do not apply to:

25 (a) a person licensed to sell any kind of insurance for which an examination is not required under
26 33-17-212(7)(d) through ~~(7)(h)~~ (7)(i);

27 (b) a person holding a temporary license issued under 33-17-216;

28 (c) a nonresident licensee who must meet continuing education requirements in the licensee's
29 state of residence if that state grants substantially similar privileges to and has similar requirements for
30 residents of this state;

1 (d) a newly licensed insurance producer or consultant during the calendar year in which the
2 licensee first received a license;

3 (e) a person who only executes surety bail bonds; or

4 (f) an insurance producer or consultant otherwise exempted by the commissioner."
5

6 **Section 36.** Section 33-18-301, MCA, is amended to read:

7 **"33-18-301. Prohibited relations with mortuaries.** (1) A life insurer and its board of directors,
8 officers, employees, or representatives may not own, manage, supervise, operate, or maintain any
9 mortuary, funeral, or undertaking establishment in Montana.

10 (2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that
11 the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any
12 person insured by the insurer. This subsection does not prohibit a life insurer from making insurance,
13 designated as funeral insurance, available.

14 (3) A funeral insurance policy and any solicitation material for the policy must clearly indicate
15 that:

16 (a) the policy is a life insurance product;

17 (b) the applicant may designate the beneficiary, ~~provided that~~ if there is an appropriate and
18 insurable interest;

19 (c) the beneficiary may use the proceeds for any purpose; and

20 (d) any attempt by the insurer or its representative to have the insured designate a specific
21 beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation
22 of this section punishable as a misdemeanor pursuant to subsection (4).

23 (4) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than
24 \$1,000 or by imprisonment for not more than 6 months, or both."
25

26 **Section 37.** Section 33-18-1006, MCA, is amended to read:

27 **"33-18-1006. Desist orders for prohibited practices.** Violations of 33-18-221 through ~~33-18-223~~
28 33-18-224 are subject to cease and desist orders of the commissioner issued under 33-18-1004."
29

30 **Section 38.** Section 33-20-121, MCA, is amended to read:

1 **"33-20-121. Prohibited provisions -- limitations on liability. (1) A policy of life insurance may not**
2 **be delivered or issued for delivery in this state if it contains a provision:**

3 **(a) for a period shorter than that provided by statute within which an action at law or in equity**
4 **may be commenced on the policy; or**

5 **(b) that excludes or restricts liability for death caused in a certain specified manner or occurring**
6 **while the insured has a specified status, except that a policy may contain provisions excluding or**
7 **restricting coverage as specified in the policy in the event of death:**

8 **(i) as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces**
9 **or of an act or hazard of war or action or of service in the military, naval, or air forces or in civilian forces**
10 **auxiliary to those military forces or from any cause while a member of military, naval, or air forces of a**
11 **country at war, declared or undeclared, or of a country engaged in military action;**

12 **(ii) as a result of aviation, air travel, or flight;**

13 **(iii) as a result of a specified hazardous occupation or occupations;**

14 **(iv) while the insured is a resident outside the continental United States and Canada; or**

15 **(v) within 2 years from the date of issue of the policy as a result of suicide, ~~while committed~~**
16 **~~pursuant to 53-21-127.~~ If a life insurance policy contains a dependent rider, the dependent coverage may**
17 **be continued upon payment of the premium for the dependent rider.**

18 **(2) A policy that contains an exclusion or restriction pursuant to subsection (1) must also provide**
19 **that in the event of death under the circumstances to which the exclusion or restriction is applicable, the**
20 **insurer will pay an amount not less than a reserve determined according to the commissioner's reserve**
21 **valuation method on the basis of the mortality table and interest rate specified in the policy for the**
22 **calculation of nonforfeiture benefits ~~for, if the policy does not provide for nonforfeiture benefits, computed~~**
23 **~~according to a mortality table and interest rate determined by the insurer and specified in the policy~~ or**
24 **by any other method more favorable to the policyholder, with adjustment for indebtedness or dividend**
25 **credit.**

26 **(3) This section does not apply to industrial life insurance, group life insurance, disability**
27 **insurance, reinsurance, or annuities or to a provision in a life insurance policy relating to disability benefits**
28 **or to additional benefits in the event of death by accident or accidental means.**

29 **(4) This section does not prohibit a provision that in the opinion of the commissioner is more**
30 **favorable to the policyholder than a provision permitted by this section."**

A handwritten mark, possibly a signature or initials, located in the bottom right corner of the page.

Section 39. Section 33-20-1201, MCA, is amended to read:

"33-20-1201. Provisions required in group contracts. No A policy of group life insurance ~~shall~~ may not be delivered in this state unless it contains in substance the provisions set forth in ~~33-20-1202 through 33-20-1211~~ this part or provisions ~~which that~~ in the opinion of the commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder; ~~except, however, that:~~

(1) ~~sections~~ 33-20-1207 through 33-20-1211 ~~shall~~ do not apply to policies issued to a creditor to insure debtors of ~~such the~~ creditor;

(2) the standard provisions required for individual life insurance policies ~~shall~~ do not apply to group life insurance policies; and

(3) if the group life insurance policy is on a plan of insurance other than the term plan, it ~~shall~~ must contain a nonforfeiture provision or provisions ~~which that~~ in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but nothing ~~herein shall~~ in this subsection may be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies."

Section 40. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-130 through ~~33-22-132, 33-22-134,~~ 33-22-135, 33-22-141, 33-22-142, 33-22-243, and 33-22-304; and part 19 of this chapter, do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled,

as defined by the contract or supplemental contract;

(4) reinsurance."

Section 41. Section 33-22-111, MCA, is amended to read:

"33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged. (1) All policies of disability insurance, including individual, group, and blanket policies, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social worker, licensed professional counselor, acupuncturist, or ~~nurse-specialist~~ advanced practice registered nurse as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 42. Section 33-22-140, MCA, is amended to read:

"33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as it relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, Public Law 93-406; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

(i) a group health plan;

(ii) health insurance coverage;

1 (iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42
2 U.S.C. 1395j through 1395w-4;

3 (iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage
4 consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

5 (v) Title 10, chapter 55, United States Code;

6 (vi) a medical care program of the Indian health service or of a tribal organization;

7 (vii) the Montana comprehensive health association provided for in 33-22-1503;

8 (viii) a health plan offered under Title 5, chapter 89, of the United States Code;

9 (ix) a public health plan;

10 (x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

11 (b) Creditable coverage does not include coverage consisting solely of coverage of excepted
12 benefits.

13 (5) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific
14 condition that would otherwise be covered under the policy.

15 (6) "Enrollment date" means, with respect to an individual covered under a group health plan or
16 health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier,
17 the first day of the waiting period for enrollment.

18 (7) "Excepted benefits" means:

19 (a) coverage only for accident, or disability income insurance, or both;

20 (b) coverage issued as a supplement to liability insurance;

21 (c) liability insurance, including general liability insurance and automobile liability insurance;

22 (d) workers' compensation or similar insurance;

23 (e) automobile medical payment insurance;

24 (f) credit-only insurance;

25 (g) coverage for onsite medical clinics;

26 (h) other similar insurance coverage under which benefits for medical care are secondary or
27 incidental to other insurance benefits, as approved by the commissioner;

28 (i) if offered separately, any of the following:

29 (i) limited-scope dental or vision benefits;

30 (ii) benefits for long-term care, nursing home care, home health care, community-based care, or

1 any combination of these types of care; or

2 (iii) other similar, limited benefits as approved by the commissioner;

3 (j) if offered as independent, noncoordinated benefits, any of the following:

4 (i) coverage only for a specified disease or illness; or

5 (ii) hospital indemnity or other fixed indemnity insurance;

6 (k) if offered as a separate insurance policy:

7 (i) medicare supplement coverage;

8 (ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United

9 States Code; and

10 (iii) similar supplemental coverage provided under a group health plan.

11 (8) "Federally defined eligible individual" means an individual:

12 (a) for whom, as of the date on which the individual seeks coverage in the group market or
13 individual market or under an association portability plan, as defined in 33-22-1501, the aggregate of the
14 periods of creditable coverage is 18 months or more;

15 (b) whose most recent prior creditable coverage was under a group health plan, governmental
16 plan, church plan, or health insurance coverage offered in connection with any of those plans;

17 (c) who is not eligible for coverage under:

18 (i) a group health plan;

19 (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42
20 U.S.C. 1395j through 1395w-4; or

21 (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or
22 a successor program;

23 (d) who does not have other health insurance coverage;

24 (e) for whom the most recent coverage within the period of aggregate creditable coverage was
25 not terminated for factors relating to nonpayment of premiums or fraud;

26 (f) who, if offered the option of continuation coverage under a COBRA continuation provision or
27 under a similar state program, elected that coverage; and

28 (g) who has exhausted continuation coverage under the COBRA continuation provision or program
29 described in subsection (8)(f) if the individual elected the continuation coverage described in subsection
30 (8)(f).

(9) "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.

(10) "Group health plan" means an employee welfare benefit plan, as defined in, 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(11) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(12) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(13) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(14) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan insurance coverage.

(15) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(16) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage when the group of eligible individuals numbered at least 51 on the first day of the plan year ~~maintained by a large employer~~.

(17) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if:

~~(a) the individual requests enrollment within 63 days after termination of the creditable coverage~~

1 end:

2 ~~_____ (i) the individual was covered under creditable coverage at the time of the initial enrollment; or~~

3 ~~_____ (ii) the individual lost coverage under creditable coverage as a result of termination of employment~~
4 ~~or eligibility, reduction in the number of hours of employment, involuntary termination of the creditable~~
5 ~~coverage, the death of a spouse, divorce, or legal separation;~~

6 ~~_____ (b) the individual is employed by an employer that offers multiple health benefit plans and the~~
7 ~~individual elects a different plan during an open enrollment period; or~~

8 ~~_____ (c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under~~
9 ~~a covered employee's health benefit plan and a request for enrollment is made within 30 days after~~
10 ~~issuance of the court order.~~

11 (18) "Medical care" means:

12 (a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the
13 purpose of affecting any structure or function of the body;

14 (b) transportation primarily for and essential to medical care referred to in subsection (18)(a); or

15 (c) insurance covering medical care referred to in subsections (18)(a) and (18)(b).

16 (19) "Network plan" means health insurance coverage offered by a health insurance issuer under
17 which the financing and delivery of medical care, including items and services paid for as medical care,
18 are provided, in whole or in part, through a defined set of providers under contract with the issuer.

19 (20) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement
20 Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

21 (21) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion
22 of benefits relating to a condition based on presence of a condition before the enrollment date coverage,
23 whether or not any medical advice, diagnosis, care, or treatment was recommended or received before
24 the enrollment date.

25 (22) "Small group market" means the health insurance market under which individuals obtain
26 health insurance coverage directly or through an arrangement, on behalf of themselves and their
27 dependents, through a group health plan or group health insurance coverage when the group of eligible
28 individuals numbered at least 2 but not more than 50 on the first day of the plan year maintained by a
29 small employer, as defined in 33-22-1803.

30 (23) "Waiting period" means, with respect to a group health plan and an individual who is a

1 potential participant or beneficiary in the group health plan, the period that must pass with respect to the
2 individual before the individual is eligible to be covered for benefits under the terms of the group health
3 plan."

4
5 **Section 43.** Section 33-22-205, MCA, is amended to read:

6 **"33-22-205. Time limit on certain defenses.** (1) There ~~shall~~ must be a provision as follows:

7 "Time Limit on Certain Defenses: (1) After 2 years from the date of issue of this policy, ~~no~~
8 misstatements, except fraudulent misstatements, made by the applicant in the application for ~~such the~~
9 policy ~~shall~~ may not be used to void the policy or to deny a claim for loss incurred or disability, ~~{as defined~~
10 in the policy}, ~~commencing beginning~~ after the expiration of ~~such the~~ 2-year period.

11 (2) ~~No~~ A claim for loss incurred or disability, ~~{as defined in the policy}, commencing beginning~~
12 after 2 years from the date of issue of this policy ~~shall~~ may not be reduced or denied on the ground that
13 a disease or physical condition ~~not excluded from coverage by name or specific description effective on~~
14 ~~the date of loss~~ had existed prior to the effective date of coverage of this policy."

15 (2) Policy provision (1) of subsection (1) ~~shall~~ may not be ~~so~~ construed as to affect any legal
16 requirement for avoidance of a policy or denial of a claim during ~~such the~~ initial 2-year period or to limit
17 the application of 33-22-222 through 33-22-226 in the event of misstatement with respect to age or
18 occupation or other insurance.

19 (3) A policy ~~which~~ that the insured has the right to continue in force subject to its terms by the
20 timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least
21 5 years from its date of issue, may contain in lieu of policy provision (1) of subsection (1) the following
22 provision, ~~{from which the clause in parentheses may be omitted at the insurer's option}, under the~~
23 caption "Incontestable":

24 "After this policy has been in force for a period of 2 years during the lifetime of the insured
25 (excluding any period during which the insured is disabled), ~~it shall become~~ the policy becomes
26 incontestable as to the statements contained in the application."

27
28 **Section 44.** Section 33-22-307, MCA, is amended to read:

29 **"33-22-307. Continuity of coverage.** (1) Subject to the requirements of 33-22-305 through
30 33-22-311 and on the date specified in the policy under which coverage otherwise terminates because

1 and:

2 ~~— (i) the individual was covered under creditable coverage at the time of the initial enrollment, or~~

3 ~~— (ii) the individual lost coverage under creditable coverage as a result of termination of employment~~
4 ~~or eligibility, reduction in the number of hours of employment, involuntary termination of the creditable~~
5 ~~coverage, the death of a spouse, divorce, or legal separation;~~

6 ~~— (b) the individual is employed by an employer that offers multiple health benefit plans and the~~
7 ~~individual elects a different plan during an open enrollment period; or~~

8 ~~— (c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under~~
9 ~~a covered employee's health benefit plan and a request for enrollment is made within 30 days after~~
10 ~~issuance of the court order.~~

11 (18) "Medical care" means:

12 (a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the
13 purpose of affecting any structure or function of the body;

14 (b) transportation primarily for and essential to medical care referred to in subsection (18)(a); or

15 (c) insurance covering medical care referred to in subsections (18)(a) and (18)(b).

16 (19) "Network plan" means health insurance coverage offered by a health insurance issuer under
17 which the financing and delivery of medical care, including items and services paid for as medical care,
18 are provided, in whole or in part, through a defined set of providers under contract with the issuer.

19 (20) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement
20 Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

21 (21) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion
22 of benefits relating to a condition based on presence of a condition before the enrollment date coverage,
23 whether or not any medical advice, diagnosis, care, or treatment was recommended or received before
24 the enrollment date.

25 (22) "Small group market" means the health insurance market under which individuals obtain
26 health insurance coverage directly or through an arrangement, on behalf of themselves and their
27 dependents, through a group health plan or group health insurance coverage when the group of eligible
28 individuals numbered at least 2 but not more than 50 on the first day of the plan year maintained by a
29 small employer, as defined in 33-22-1803.

30 (23) "Waiting period" means, with respect to a group health plan and an individual who is a

1 potential participant or beneficiary in the group health plan, the period that must pass with respect to the
2 individual before the individual is eligible to be covered for benefits under the terms of the group health
3 plan."

4
5 Section 43. Section 33-22-205, MCA, is amended to read:

6 "33-22-205. Time limit on certain defenses. (1) There ~~shall~~ must be a provision as follows:

7 "Time Limit on Certain Defenses: (1) After 2 years from the date of issue of this policy, ~~no~~
8 misstatements, except fraudulent misstatements, made by the applicant in the application for ~~such the~~
9 policy ~~shall~~ may not be used to void the policy or to deny a claim for loss incurred or disability, ~~as defined~~
10 in the policy, commencing beginning after the expiration of ~~such the~~ 2-year period.

11 (2) ~~No A~~ claim for loss incurred or disability, ~~as defined in the policy, commencing beginning~~
12 after 2 years from the date of issue of this policy ~~shall~~ may not be reduced or denied on the ground that
13 a disease or physical condition ~~not excluded from coverage by name or specific description effective on~~
14 ~~the date of loss~~ had existed prior to the effective date of coverage of this policy."

15 (2) Policy provision (1) of subsection (1) ~~shall~~ may not be ~~so~~ construed as to affect any legal
16 requirement for avoidance of a policy or denial of a claim during ~~such the~~ initial 2-year period or to limit
17 the application of 33-22-222 through 33-22-226 in the event of misstatement with respect to age or
18 occupation or other insurance.

19 (3) A policy ~~which that~~ the insured has the right to continue in force subject to its terms by the
20 timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least
21 5 years from its date of issue; may contain in lieu of policy provision (1) of subsection (1) the following
22 provision, ~~from which the clause in parentheses may be omitted at the insurer's option,~~ under the
23 caption "Incontestable":

24 "After this policy has been in force for a period of 2 years during the lifetime of the insured
25 (excluding any period during which the insured is disabled), ~~it shall become~~ the policy becomes
26 incontestable as to the statements contained in the application."

27
28 Section 44. Section 33-22-307, MCA, is amended to read:

29 "33-22-307. Continuity of coverage. (1) Subject to the requirements of 33-22-305 through
30 33-22-311 and on the date specified in the policy under which coverage otherwise terminates because

of the death of the named insured or for any other reason specified in 33-22-306, as to covered family members, other than for nonpayment of premium, nonrenewal of the policy, or the expiration of the term for which the policy is issued, a covered person, {other than one eligible for medicare or any other similar federal or state disability insurance program}, including the spouse and any covered dependent child of the last-named insured or the representative of such the child, has the right to continuation of coverage under provisions that, at the option of the carrier, are consistent with:

(a) the continuation of the policy, with the person exercising the right of continuation designated as the named insured;

(b) the issuance of a converted policy with the person exercising the conversion right designated as the named insured; or

(c) both (1)(a) and (1)(b).

(2) When continuation of coverage or conversion is made in the name of the spouse of the named insured, the coverage may, at the option of the spouse, include covered dependent children for whom the spouse has the responsibility for care and support."

Section 45. Section 33-22-514, MCA, is amended to read:

"33-22-514. Preexisting conditions relating to group market. (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a preexisting condition unless:

(a) medical advice, diagnosis, care, or treatment was recommended or received by the participant or beneficiary within the 6-month period ending on the enrollment date;

(b) exclusion of coverage extends for a period of not more than 12 months or 18 months in the case of a late enrollee; and

(c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(2) Genetic information may not be excluded as a preexisting condition in the absence of a diagnosis of the condition related to the genetic information.

(3) Pregnancy may not be excluded as a preexisting condition."

Section 46. Section 33-22-523, MCA, is amended to read:

1 **"33-22-523. Special enrollment periods.** (1) A group health plan and a health insurance issuer
2 offering group health insurance coverage in connection with a group health plan shall permit an employee
3 or a dependent of an employee who is eligible, but not enrolled, for coverage under the terms of the group
4 health plan to enroll for coverage under the terms of the group health plan if:

5 (a) the employee or dependent was covered under a group health plan or had health insurance
6 coverage at the time that coverage was previously offered to the employee or dependent;

7 (b) the employee stated in writing at the time that coverage under a group health plan or health
8 insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health
9 insurance issuer required the statement at the time and provided the employee with notice of the
10 requirement and the consequences of the requirement at the time;

11 (c) the employee's or dependent's coverage described in subsection (1)(a) was:

12 (i) under a COBRA continuation provision and was exhausted; or

13 (ii) not under a COBRA continuation provision and was terminated as a result of loss of eligibility
14 for the coverage or because employer contributions toward the coverage were terminated; and

15 (d) under the terms of the group health plan, the employee requests the enrollment not later than
16 30 days after the date of exhaustion of coverage described in subsection (1)(c)(i) or termination of
17 coverage or employer contribution described in subsection (1)(c)(ii).

18 (2) (a) A group health plan ~~shall~~ must provide for a dependent special enrollment period described
19 in subsection (2)(b) during which a dependent may be enrolled under the group health plan as a dependent
20 of the individual ~~and, if the person becomes a dependent of the individual through marriage, birth,~~
21 adoption, or placement for adoption. ~~in~~ In the case of the birth or adoption of a child, the spouse of the
22 individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

23 (b) A dependent special enrollment period under this subsection (2) is a period of not less than
24 30 days that begins on the later of:

25 (i) the date dependent coverage is made available; or

26 (ii) the date of the marriage, birth, ~~or~~ adoption, or placement for adoption.

27 (3) If an individual seeks to enroll a dependent during the first 30 days of the dependent special
28 enrollment period, the coverage of the dependent becomes effective:

29 (a) in the case of marriage, not later than the first day of the first month beginning after the date
30 on which the completed request for enrollment is received;

1 (b) in the case of a dependent's birth, as of the date of birth; or

2 (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or
3 placement for adoption."

4
5 **Section 47. Section 33-22-524, MCA, is amended to read:**

6 **"33-22-524. Guaranteed renewability of coverage for employers in group market. (1) Except as**
7 **provided in this section, if a health insurance issuer offers health insurance coverage in the small group**
8 **market or large group market in connection with a group health plan, the health insurance issuer shall**
9 **renew or continue the coverage in force at the option of the plan sponsor.**

10 (2) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in
11 connection with a group health plan in the small group market or large group market if:

12 (a) the plan sponsor has failed to pay premiums or contributions in accordance with the terms
13 of the health insurance coverage or if the health insurance issuer has not received timely premium
14 payments;

15 (b) the plan sponsor has performed an act or practice that constitutes fraud or has made an
16 intentional misrepresentation of material fact under the terms of the coverage;

17 (c) the plan sponsor has failed to comply with a material plan provision relating to employer
18 contribution or group health plan participation rules ~~in the case of the small group market or pursuant to~~
19 ~~applicable state law in the case of the large group market;~~

20 (d) the health insurance issuer is ceasing to offer coverage in that group market in accordance
21 with this section and applicable state law;

22 (e) in the case of a health insurance issuer that offers health insurance coverage in the group
23 market through a network plan, there is no longer any enrollee in connection with the group health plan
24 who lives, resides, or works in the service area of the health insurance issuer and, in the case of the small
25 group market, if the health insurance issuer would deny enrollment with respect to the plan under
26 33-22-1811(4)(a)(i); or

27 (f) in the case of health insurance coverage that is made available in the small group market or
28 large group market only through one or more bona fide associations, the membership of an employer in
29 the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(f)
30 uniformly without regard to any health status-related factor of a covered individual.

1 (3) A health insurance issuer may not discontinue offering a particular type of group health
2 insurance coverage offered in the small group market or large group market unless in accordance with
3 applicable state law and unless:

4 (a) the issuer provides notice to each plan sponsor, participant, and beneficiary provided coverage
5 of this type in that group market of the discontinuation at least 90 days prior to the date of the
6 discontinuation of the coverage;

7 (b) the issuer offers to each plan sponsor provided coverage of this type in the market the option
8 to purchase any other health insurance coverage currently being offered by the health insurance issuer
9 to a group health plan in the market; and

10 (c) the health insurance issuer acts uniformly without regard to the claims experience of those
11 sponsors or any health status-related factor of any participants or beneficiaries covered or new
12 participants or beneficiaries who may become eligible for the coverage.

13 (4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the
14 small group market, the large group market, or both the small group market and the large group market,
15 unless in accordance with applicable state law and unless:

16 (i) the issuer provides notice of discontinuation to the commissioner and to each plan sponsor,
17 participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage;
18 and

19 (ii) all health insurance issued or delivered for issuance in Montana in the group market or markets
20 is discontinued and coverage under the health insurance coverage in the group market or markets is not
21 renewed.

22 (b) In the case of a discontinuation under this section in a group market, the health insurance
23 issuer may not provide for the issuance of any health insurance coverage in the group market for a period
24 of 5 years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

25 (5) A health insurance issuer may modify upon renewal health insurance coverage for a product
26 offered to a group health plan in the large group market or in the small group market if, for coverage that
27 is available in the small group market other than only through one or more bona fide associations,
28 modification is consistent with applicable state law and effective on a uniform basis among group health
29 plans with that product.

30 (6) In the case of health insurance coverage that is made available by a health insurance issuer

1 in the small group market or large group market to employers only through one or more bona fide
2 associations, references to "plan sponsor" under this section include those employers."

3
4 Section 48. Section 33-22-703, MCA, is amended to read:

5 "33-22-703. (Temporary) Coverage for mental illness, alcoholism, and drug addiction. (1) A group
6 health plan or a health insurance issuer that provides group health insurance coverage shall provide for
7 Montana residents covered by the plan at least the following level of benefits provided for under
8 subsections (1)(a) through (1)(e) for the necessary care and treatment of mental illness, alcoholism, and
9 drug addiction:

10 ~~—— (a) under basic inpatient expense policies or contracts; or major medical policies or contracts,~~
11 ~~including inpatient hospital and outpatient benefits~~ consisting of durational limits, dollar limits, deductibles,
12 and coinsurance factors that are not less favorable than for physical illness generally, except that:

13 ~~(i)(a)~~ inpatient treatment for mental illness, alcoholism, and drug addiction is may be subject to
14 a maximum yearly benefit of 21 days;

15 ~~(ii)(b)~~ inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for
16 partial hospitalization through a program that complies with the standards for a partial hospitalization
17 program that are published by the American association for partial hospitalization if the program is
18 operated by a hospital; ~~and~~

19 ~~(iii)(c)~~ inpatient treatment for alcoholism and drug addiction is may be subject to a maximum
20 benefit of \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;

21 ~~(b) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting~~
22 ~~of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for~~
23 ~~physical illness generally, except that:~~

24 ~~—— (i) inpatient treatment for mental illness, alcoholism, and drug addiction is subject to a maximum~~
25 ~~yearly benefit of 21 days;~~

26 ~~—— (ii) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial~~
27 ~~hospitalization through a program that complies with the standards for a partial hospitalization program~~
28 ~~that are published by the American association for partial hospitalization if the program is operated by a~~
29 ~~hospital;~~

30 ~~—— (iii) inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit~~

1 of ~~\$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;~~

2 ~~(iv)~~(d) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no
3 less than \$2,000, but this subsection ~~(i)(b)(iv)~~ (1)(d) does not apply to benefits for services furnished
4 before September 30, 2001, unless the group health plan or group health insurance coverage is exempt
5 from the requirements of subsection (2) pursuant to subsection (3) or (4); and

6 ~~(v)~~(e) outpatient treatment for alcoholism and drug addiction ~~is~~ may be subject to a maximum
7 yearly benefit of \$1,000.

8 (2) A group health plan or group health insurance coverage offered in connection with a group
9 health plan may not impose an aggregate dollar limit on an annual or lifetime basis more restrictively for
10 mental health benefits than for medical and surgical benefits covered by the plans. In the case of a plan
11 that has different aggregate lifetime limits and different annual limits on various categories of medical and
12 surgical benefits, the commissioner shall establish rules for determining a weighted average aggregate
13 lifetime limit and weighted average annual limit to apply to mental health benefits. This subsection does
14 not apply to benefits for services furnished on or after September 30, 2001.

15 (3) Subsection (2) does not apply to a group health plan or health insurance coverage offered in
16 connection with a group health plan in the small group market.

17 (4) Subsection (2) does not apply to a group health plan or health insurance coverage offered in
18 connection with a group health plan if the application of subsection (2) results in an increase in the cost
19 under the group health plan or for coverage of at least 1%. This subsection applies separately to each
20 benefit package option in the case of a group health plan that offers a participant or beneficiary two or
21 more benefit package options under the group health plan. (Terminates September 30, 2001--sec. 54, Ch.
22 416, L. 1997.)

23 **33-22-703. (Effective October 1, 2001) Coverage for mental illness, alcoholism, and drug**
24 **addiction. A group health plan or a health insurance issuer that provides group health insurance coverage**
25 **shall provide for Montana residents covered by the plan at least the following level of benefits provided**
26 **for under subsections (1) through (5) for the necessary care and treatment of mental illness, alcoholism,**
27 **and drug addiction:**

28 ~~—— (1) under basic inpatient expense policies or contracts; or major medical policies or contracts.~~
29 including inpatient hospital and outpatient benefits consisting of durational limits, dollar limits, deductibles,
30 and coinsurance factors that are not less favorable than for physical illness generally, except that:

1 ~~(a)~~(1) inpatient treatment for mental illness, alcoholism, and drug addiction ~~is~~ may be subject to
2 a maximum yearly benefit of 21 days;

3 ~~(b)~~(2) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for
4 partial hospitalization through a program that complies with the standards for a partial hospitalization
5 program that are published by the American association for partial hospitalization if the program is
6 operated by a hospital; and

7 ~~(c)~~(3) inpatient treatment for alcoholism and drug addiction ~~is~~ may be subject to a maximum
8 benefit of \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;

9 ~~— (2) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting~~
10 ~~of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for~~
11 ~~physical illness generally, except that:~~

12 ~~— (a) inpatient treatment for mental illness, alcoholism, and drug addiction is subject to a maximum~~
13 ~~yearly benefit of 21 days;~~

14 ~~— (b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial~~
15 ~~hospitalization through a program that complies with the standards for a partial hospitalization program~~
16 ~~that are published by the American association for partial hospitalization if the program is operated by a~~
17 ~~hospital;~~

18 ~~— (c) inpatient treatment for alcoholism and drug addiction may be subject to a maximum benefit~~
19 ~~of \$4,000 in any 24-month period and a maximum lifetime benefit of \$8,000;~~

20 ~~(d)~~(4) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no
21 less than \$2,000, but this subsection ~~(2)(d)~~ (4) does not apply to benefits for services furnished before
22 September 30, 2001; and

23 ~~(e)~~(5) outpatient treatment for alcoholism and drug addiction ~~is~~ may be subject to a maximum
24 yearly benefit of \$1,000."

25
26 Section 49. Section 33-22-1803, MCA, is amended to read:

27 "33-22-1803. Definitions. As used in this part, the following definitions apply:

28 (1) "Actuarial certification" means a written statement by a member of the American academy
29 of actuaries or other individual acceptable to the commissioner that a small employer carrier is in
30 compliance with the provisions of 33-22-1809, based upon the person's examination, including a review

1 of the appropriate records and of the actuarial assumptions and methods used by the small employer
2 carrier in establishing premium rates for applicable health benefit plans.

3 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one
4 or more intermediaries, controls, is controlled by, or is under common control with a specified entity or
5 person.

6 (3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and
7 stop loss disability insurance.

8 (4) "Base premium rate" means, for each class of business as to a rating period, the lowest
9 premium rate charged or that could have been charged under the rating system for that class of business
10 by the small employer carrier to small employers with similar case characteristics for health benefit plans
11 with the same or similar coverage.

12 (5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan,
13 developed by a small employer carrier, that has a lower benefit value than the small employer carrier's
14 standard benefit plan and that provides the benefits required by 33-22-1827.

15 (6) "Benefit value" means a numerical value based on the expected dollar value of benefits
16 payable to an insured under a health benefit plan. The benefit value must be calculated by the small
17 employer carrier using an actuarially based method and must take into account all health care expenses
18 covered by the health benefit plan and all cost-sharing features of the health benefit plan, including
19 deductibles, coinsurance, copayments, and the insured individual's maximum out-of-pocket expenses. The
20 benefit value must apply equally to indemnity-type health benefit plans and to managed care health
21 benefit plans, including health maintenance organization-type plans.

22 (7) "Board" means the board of directors of the program established pursuant to 33-22-1818.

23 (8) "Bona fide association" means an association that:

24 (a) has been actively in existence for at least 5 years;

25 (b) was formed and has been maintained in good faith for purposes other than obtaining
26 insurance;

27 (c) does not condition membership in the association on a health status-related factor relating to
28 an individual, including an employee of an employer or a dependent of an employee;

29 (d) makes health insurance coverage offered through the association available to a member
30 regardless of a health status-related factor relating to the member or an individual eligible for coverage

1 through a member; and

2 (e) does not make health insurance coverage offered through the association available other than
3 in connection with a member of the association; and,

4 ~~(f) meets any additional requirements required by law.~~

5 (9) "Carrier" means any person who provides a health benefit plan in this state subject to state
6 insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit
7 society, a health service corporation, and a health maintenance organization. For purposes of this part,
8 companies that are affiliated companies or that are eligible to file a consolidated tax return must be
9 treated as one carrier, except that the following may be considered as separate carriers:

10 (a) an insurance company or health service corporation that is an affiliate of a health maintenance
11 organization located in this state;

12 (b) a health maintenance organization located in this state that is an affiliate of an insurance
13 company or health service corporation; or

14 (c) a health maintenance organization that operates only one health maintenance organization in
15 an established geographic service area of this state.

16 (10) "Case characteristics" means demographic or other objective characteristics of a small
17 employer that are considered by the small employer carrier in the determination of premium rates for the
18 small employer, provided that gender, claims experience, health status, and duration of coverage are not
19 case characteristics for purposes of this part.

20 (11) "Class of business" means all or a separate grouping of small employers established pursuant
21 to 33-22-1808.

22 (12) "Dependent" means:

23 (a) a spouse or an unmarried child under 19 years of age;

24 (b) an unmarried child, under 23 years of age, who is a full-time student and who is financially
25 dependent on the insured;

26 (c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506
27 and 33-30-1003; or

28 (d) any other individual defined as a dependent in the health benefit plan covering the employee.

29 (13) "Eligible employee" means an employee who works on a full-time basis with a normal
30 workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include

1 an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long
2 as this eligibility criteria is applied uniformly among all of the employer's employees. The term includes
3 a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner,
4 or independent contractor is included as an employee under a health benefit plan of a small employer. The
5 term also includes those persons eligible for coverage under 2-18-704. The term does not include an
6 employee who works on a part-time, temporary, or substitute basis.

7 (14) "Established geographic service area" means a geographic area, as approved by the
8 commissioner and based on the carrier's certificate of authority to transact insurance in this state, within
9 which the carrier is authorized to provide coverage.

10 (15) "Health benefit plan" means any hospital or medical policy or certificate providing for physical
11 and mental health care issued by an insurance company, a fraternal benefit society, or a health service
12 corporation or issued under a health maintenance organization subscriber contract. Health benefit plan
13 does not include coverage of excepted benefits if coverage is provided under a separate policy, certificate,
14 or contract of insurance.

15 (16) "Index rate" means, for each class of business for a rating period for small employers with
16 similar case characteristics, the average of the applicable base premium rate and the corresponding
17 highest premium rate.

18 (17) "New business premium rate" means, for each class of business for a rating period, the
19 lowest premium rate charged or offered or that could have been charged or offered by the small employer
20 carrier to small employers with similar case characteristics for newly issued health benefit plans with the
21 same or similar coverage.

22 (18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

23 (19) "Premium" means all money paid by a small employer and eligible employees as a condition
24 of receiving coverage from a small employer carrier, including any fees or other contributions associated
25 with the health benefit plan.

26 (20) "Program" means the Montana small employer health reinsurance program created by
27 33-22-1818.

28 (21) "Rating period" means the calendar period for which premium rates established by a small
29 employer carrier are assumed to be in effect.

30 (22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program

1 pursuant to 33-22-1819.

2 (23) "Restricted network provision" means a provision of a health benefit plan that conditions the
3 payment of benefits, in whole or in part, on the use of health care providers that have entered into a
4 contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter
5 31, to provide health care services to covered individuals.

6 (24) "Small employer" means a person, firm, corporation, partnership, or bona fide association that
7 is actively engaged in business and that, with respect to a calendar year and a plan year, employed at
8 least 2 but not more than 50 eligible employees during the preceding calendar year and employed at least
9 two employees on the first day of the plan year. In the case of an employer that was not in existence
10 throughout the preceding calendar year, the determination of whether the employer is a small or large
11 employer must be based on the average number of employees reasonably expected to be employed by
12 the employer in the current calendar year. In determining the number of eligible employees, companies
13 are considered one employer if they:

14 (a) are affiliated companies;

15 (b) are eligible to file a combined tax return for purposes of state taxation; or

16 (c) are members of a bona fide association.

17 (25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible
18 employees of one or more small employers in this state.

19 (26) "Standard health benefit plan" means a health benefit plan that is developed by a small
20 employer carrier and that contains the provisions required pursuant to 33-22-1828."

21
22 **Section 50. Section 33-22-1809, MCA, is amended to read:**

23 **"33-22-1809. Restrictions relating to premium rates. (1) Premium rates for health benefit plans**
24 **under this part are subject to the following provisions:**

25 (a) The index rate for a rating period for any class of business may not exceed the index rate for
26 any other class of business by more than 20%.

27 (b) For each class of business, the premium rates charged during a rating period to small
28 employers with similar case characteristics for the same or similar coverage or the rates that could be
29 charged to the employer under the rating system for that class of business may not vary from the index
30 rate by more than 25% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

~~(f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:~~

~~—— (i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and~~

~~(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.~~

~~(g)~~(f) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups. Differences among base premium rates may not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

~~(h)~~(g) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in

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1 health status of the employees of small employers and the employees' dependents;

2 (b) the provisions of the health benefit plan concerning the small employer carrier's right to
3 change premium rates and the factors, other than claims experience, that affect changes in premium
4 rates;

5 (c) the provisions relating to renewability of policies and contracts; and

6 (d) the provisions relating to any preexisting condition.

7 (5) (a) Each small employer carrier shall maintain at its principal place of business a complete and
8 detailed description of its rating practices and renewal underwriting practices, including information and
9 documentation that demonstrate that its rating methods and practices are based upon commonly
10 accepted actuarial assumptions and are in accordance with sound actuarial principles.

11 (b) Each small employer carrier shall file with the commissioner annually, on or before March 15,
12 an actuarial certification certifying that the carrier is in compliance with this part and that the rating
13 methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form
14 and manner and must contain information as specified by the commissioner. A copy of the actuarial
15 certification must be retained by the small employer carrier at its principal place of business.

16 ~~(c) The filing required in subsection (5)(b) must contain the small employer carrier's benefit value.~~

17 ~~(d)~~ A small employer carrier shall make the information and documentation described in
18 subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the
19 provisions of this part and except as agreed to by the small employer carrier or as ordered by a court of
20 competent jurisdiction, the information must be considered proprietary and trade secret information and
21 is not subject to disclosure by the commissioner to persons outside of the department.

22 (6) The commissioner may not require prior approval of the rating methods used by small
23 employer carriers or the premium rates of the health benefit plans offered to small employers."
24

25 **Section 51. Section 33-22-1811, MCA, is amended to read:**

26 **"33-22-1811. Availability of coverage -- required plans. (1) (a) As a condition of transacting**
27 **business in this state with small employers, each small employer carrier must have approved for issuance**
28 **to small employer groups at least two health benefit plans. One plan must be a basic health benefit plan,**
29 **and one plan must be a standard health benefit plan.**

30 (b) (i) A small employer carrier shall issue ~~a basic health benefit plan or a standard health benefit~~

1 ~~plan all plans marketed under this part~~ to any eligible small employer that applies for either a plan and
2 agrees to make the required premium payments and to satisfy the other reasonable provisions of the
3 health benefit plan not inconsistent with this part. ~~If, pursuant to Public Law 104-191, an agency of the~~
4 ~~United States or a court does not prohibit a small employer carrier from doing so, a small employer carrier~~
5 ~~may offer and issue a group health benefit plan other than a basic or standard plan on an underwritten~~
6 ~~basis.~~

7 (ii) In the case of a small employer carrier that establishes more than one class of business
8 pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers
9 ~~at least one basic health benefit plan and at least one standard health benefit plan~~ all plans marketed
10 under this part in each established class of business. A small employer carrier may apply reasonable
11 criteria in determining whether to accept a small employer into a class of business, provided that:

12 (A) the criteria are not intended to discourage or prevent acceptance of small employers applying
13 for a health benefit plan;

14 (B) the criteria are not related to the health status or claims experience of the small employers'
15 employees;

16 (C) the criteria are applied consistently to all small employers that apply for coverage in that class
17 of business; and

18 (D) the small employer carrier provides for the acceptance of all eligible small employers into one
19 or more classes of business.

20 (iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which
21 the small employer carrier is no longer enrolling new small businesses.

22 (c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a)
23 and (1)(b) may continue to provide coverage under health benefit plans previously issued to small
24 employers in this state for a period of no more than 7 years from October 1, 1995, if the carrier:

25 (i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and
26 subsections (2) through (4) of this section; and

27 (ii) does not amend or alter the benefits and coverages of the previously issued health benefit
28 plans unless required to do so by law or rule; and

29 (iii) complies with all applicable provisions of Public Law 104-91.

30 (2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans

1 and the standard health benefit plans to be used by the small employer carrier.

2 (b) The commissioner may at any time, after providing notice and an opportunity for a hearing
3 to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or
4 standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

5 (3) Health benefit plans covering small employers must comply with the following provisions:

6 (a) A health benefit plan may not:

7 (i) because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for
8 losses incurred more than 12 months following the ~~effective date of the~~ individual's enrollment date
9 coverage. A health benefit plan may not define a preexisting condition exclusion more restrictively than
10 33-22-140.

11 (ii) use a preexisting condition exclusion more restrictive than exclusions allowed under 33-22-514.

12 (b) A health benefit plan must waive any time period applicable to a preexisting condition
13 exclusion or limitation period with respect to particular services for the period of time that an individual
14 was previously covered by creditable coverage that provided benefits with respect to those services if
15 the creditable coverage was continuous to a date not more than 63 days prior to the submission of an
16 application for new coverage. A health benefit plan may determine waivers of time periods applicable to
17 preexisting condition exclusions or limitations on the basis of prior coverage of benefits within each of
18 several classes or categories as specified in regulations implementing Public Law 104-191, rather than
19 as provided in this subsection (3)(b). This subsection (3)(b) does not preclude application of any waiting
20 period applicable to all new enrollees under the health benefit plan.

21 (c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an
22 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and
23 a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed
24 18 months from the date on which the individual enrolls for coverage under the health benefit plan.

25 (d) (i) Requirements used by a small employer carrier in determining whether to provide coverage
26 to a small employer, including requirements for minimum participation of eligible employees and minimum
27 employer contributions, must be applied uniformly among all small employers that have the same number
28 of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

29 (ii) A small employer carrier may vary the application of minimum participation requirements and
30 minimum employer contribution requirements only by the size of the small employer group.

1 (e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier
2 shall offer coverage to all of the eligible employees of a small employer and their dependents. A small
3 employer carrier may not offer coverage only to certain individuals in a small employer group or only to
4 part of the group, except in the case of late enrollees as provided in subsection (3)(c).

5 (ii) A small employer carrier may not modify a ~~basic or standard health benefit plan~~ marketed under
6 this part with respect to a small employer or any eligible employee or dependent, through riders,
7 endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions
8 otherwise covered by the health benefit plan.

9 (iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who
10 declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan
11 provided by the small employer. The waiver must be signed by the eligible employee and must certify that
12 the employee was informed of the availability of coverage under the health benefit plan and of the
13 penalties for late enrollment. The waiver may not require the eligible employee to disclose the reasons for
14 declining coverage.

15 (iv) A small employer carrier may not issue coverage to a small employer if the carrier or a
16 producer for the carrier has evidence that the small employer induced or pressured an eligible employee
17 to decline coverage due to the health status or risk characteristics of the eligible employee or of the
18 dependents of the eligible employee.

19 (4) (a) A small employer carrier may not be required to offer coverage or accept applications
20 pursuant to subsection (1) in the case of the following:

21 (i) to an employer whose employees do not work or reside within the small employer carrier's
22 established geographic service area for a network plan, as defined in 33-22-140; or

23 (ii) within an area where the small employer carrier reasonably anticipates and demonstrates to
24 the satisfaction of the commissioner that it will not have the capacity within its established geographic
25 service area to deliver service adequately to the members of a group because of its obligations to existing
26 group policyholders and enrollees. The small employer carrier may not deny coverage under this
27 subsection unless the small employer carrier acts uniformly without regard to claims experience or health
28 status-related factors of employers, employees, or dependents.

29 (b) A small employer carrier may not be required to provide coverage to small employers pursuant
30 to subsection (1) for which the commissioner determines that the small employer carrier does not have

1 the financial reserves necessary to underwrite additional coverage and that the small employer carrier has
2 denied coverage of small employers uniformly throughout the state and without regard to the claims
3 experience and health status-related factors of the applicant small employer groups. The small employer
4 carrier exempted from providing coverage under this subsection may not offer coverage to small employer
5 groups in this state for 180 days after the date on which coverage is denied or until the small employer
6 carrier has demonstrated to the commissioner that the small employer carrier has sufficient financial
7 reserves to underwrite additional coverage, whichever is later."

8
9 **Section 52. Section 33-22-1813, MCA, is amended to read:**

10 **"33-22-1813. Standards to ensure fair marketing. (1) Each small employer carrier shall actively**
11 **market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small**
12 **employers in the state. ~~If a small employer carrier denies coverage other than the basic or standard health~~**
13 **~~benefit plans to a small employer on the basis of claims experience of the small employer or the health~~**
14 **~~status or claims experience of its employees or dependents, the small employer carrier shall offer the~~**
15 **~~small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.~~**

16 (2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not
17 directly or indirectly engage in the following activities:

18 (i) encouraging or directing small employers to refrain from filing an application for coverage with
19 the small employer carrier because of the health status of the employer's employees or the claims
20 experience, industry, occupation, or geographic location of the small employer;

21 (ii) encouraging or directing small employers to seek coverage from another carrier because of the
22 health status of the employer's employees or the claims experience, industry, occupation, or geographic
23 location of the small employer.

24 (b) The provisions of subsection (2)(a) do not apply with respect to information provided by a
25 small employer carrier or producer to a small employer regarding the established geographic service area
26 or a restricted network provision of a small employer carrier.

27 (3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or
28 indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results
29 in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the
30 health status of the employer's employees or the claims experience, industry, occupation, or geographic

1 location of the small employer.

2 (b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides
3 compensation to a producer on the basis of the percentage of a premium, provided that the percentage
4 may not vary because of the health status of the employer's employees or the claims experience,
5 industry, occupation, or geographic area of the small employer.

6 (4) A small employer carrier shall provide reasonable compensation, as provided under the plan
7 of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

8 (5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement
9 of representation with a producer for any reason related to the health status of the employer's employees
10 or the claims experience, industry, occupation, or geographic location of the small employers placed by
11 the producer with the small employer carrier.

12 (6) A small employer carrier or producer may not induce or otherwise encourage a small employer
13 to separate or otherwise exclude an employee from health coverage or benefits provided in connection
14 with the employee's employment.

15 (7) Denial by a small employer carrier of ~~an application for coverage from~~ health insurance
16 coverage for a small employer must be in writing and must state the reason or reasons for the denial.

17 (8) The commissioner may adopt rules setting forth additional standards to provide for the fair
18 marketing and broad availability of health benefit plans to small employers in this state.

19 (9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade
20 practice under 33-18-102.

21 (b) If a small employer carrier enters into a contract, agreement, or other arrangement with an
22 administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative,
23 marketing, or other services related to the offering of health benefit plans to small employers in this state,
24 the administrator is subject to this section as if the administrator were a small employer carrier."
25

26 Section 53. Section 33-22-1815, MCA, is amended to read:

27 "33-22-1815. Qualifications for voluntary purchasing pool. A voluntary purchasing pool of
28 disability insurance purchasers may be formed solely for the purpose of obtaining disability insurance upon
29 compliance with the following provisions:

30 (1) It contains at least 1,000 eligible employees.

(2) It establishes requirements for membership. The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with more than 25 50 eligible employees that otherwise meet the requirements for membership. However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience, occupation, or health status.

(3) It holds an open enrollment period at least once a year during which new members can join the voluntary purchasing pool.

(4) It offers coverage to eligible employees of member employers and to the employees' dependents. Coverage may not be limited to certain employees of member small employers except as provided in 33-22-1811(3)(c).

(5) It does not assume any risk or form self-insurance plans among its members.

(6) (a) It has the option of using the following types of rating arrangements with the disability insurance policies, certificates, or contracts:

(i) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool that rate each member employer separately are subject to the provisions of this part.

(ii) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool that rate the entire group as a whole must charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by the laws governing group disability insurance.

(b) At its discretion, premiums may be paid to the disability insurance policies, certificates, or contracts by the voluntary purchasing pool, by member employers, or by eligible employees and their dependents.

(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

Section 54. Section 33-22-1816, MCA, is amended to read:

"33-22-1816. Commissioner powers and duties -- application for registration -- reporting insolvency. (1) The commissioner shall develop forms for registration of an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application

1 to the commissioner. The commissioner shall register an organization as a voluntary purchasing pool upon
2 proof of fulfillment of the qualifications provided in 33-22-1815.

3 (3) ~~On~~ Except as provided in subsection (5), on March 1 of each year, the voluntary purchasing
4 pool shall provide a report and financial statement for the previous calendar year to the commissioner in
5 order that the commissioner may determine:

6 (a) whether the operation of the voluntary purchasing pool is fiscally sound;

7 (b) whether the voluntary purchasing pool is bearing any risk; and

8 (c) the number of individuals covered.

9 (4) The annual report of the voluntary purchasing pool must disclose its total administrative cost.

10 (5) A voluntary purchasing pool may choose to operate on a fiscal year other than on the calendar
11 year. A voluntary purchasing pool that establishes a fiscal year that is other than the calendar year shall
12 provide the report required in subsection (3) to the commissioner within 60 days of the voluntary
13 purchasing pool's fiscal yearend."
14

15 Section 55. Section 33-22-1819, MCA, is amended to read:

16 "33-22-1819. Program plan of operation -- treatment of losses -- exemption from taxation. (1)
17 ~~Within 180 days after the appointment of the initial board, the~~ The board shall ~~submit to the commissioner~~
18 ~~for review~~ maintain a plan of operation and may at any time submit to the commissioner amendments to
19 the plan ~~necessary or suitable to ensure the fair, reasonable, and equitable administration of the program.~~
20 The commissioner may review the plan of operation to determine if it is suitable to ensure the fair,
21 reasonable, and equitable administration of the program and if the plan of operation provides for the
22 sharing of program gains or losses on an equitable and proportionate basis in accordance with the
23 provisions of this section. The commissioner may make recommendations to the board if the
24 commissioner determines that the plan of operation does not meet the criteria of this subsection.

25 (2) The plan of operation must:

26 (a) establish procedures for the handling and accounting of program assets and money and for
27 an annual fiscal reporting to the commissioner;

28 (b) establish procedures for selecting an administering carrier and setting forth the powers and
29 duties of the administering carrier;

30 (c) establish procedures for reinsuring risks in accordance with the provisions of this section;

(d) establish procedures for collecting assessments from assessable carriers to fund claims incurred by the program;

(e) establish procedures for allocating a portion of premiums collected from reinsuring carriers to fund administrative expenses incurred or to be incurred by the program; and

(f) provide for any additional matters necessary for the implementation and administration of the program.

(3) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. In addition, the program may:

(a) enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(b) sue or be sued, including taking any legal actions necessary or proper to recover any premiums and penalties for, on behalf of, or against the program or any reinsuring carriers;

(c) take any legal action necessary to avoid the payment of improper claims against the program;

(d) define the health benefit plans for which reinsurance will be provided and to issue reinsurance policies in accordance with the requirements of this part;

(e) establish conditions, eligibility requirements, and procedures for reinsuring risks under the program;

(f) establish actuarial functions as appropriate for the operation of the program;

(g) appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in operation of the program, policy and other contract design, and any other function within the authority of the program;

(h) to the extent permitted by federal law and in accordance with subsection (7)(c), make annual assessments against assessable carriers and make interim assessments to fund claims incurred by the program; and

(i) borrow money to effect the purposes of the program. Any notes or other evidence of indebtedness of the program not in default are legal investments for carriers and may be carried as admitted assets.

1 (4) A reinsuring carrier may reinsure with the program as provided for in this subsection:

2 (a) With respect to a basic health benefit plan or a standard health benefit plan, the program shall
3 reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to
4 the level of coverage provided in a basic or standard health benefit plan.

5 (b) A small employer carrier may reinsure an entire employer group within 60 days of the
6 commencement of the group's coverage under a health benefit plan. A carrier may reinsure a newborn
7 only if the child's mother is already insured at the time of birth. However, a child born within the 60 days
8 that a carrier is allowed to cede a group and who is covered as a dependent is included as part of the
9 ceded group whether or not the mother is covered under the group.

10 (c) A reinsuring carrier may reinsure an eligible employee or dependent within a period of 60 days
11 following the commencement of coverage with the small employer. A newly eligible employee or
12 dependent of the reinsured small employer may be reinsured within 60 days of the commencement of
13 coverage. However, a carrier may not reinsure a newborn if the child's mother is not already reinsured
14 at the time of the child's birth, unless the birth occurs within the 60 days following the commencement
15 of the employee's coverage.

16 (d) (i) The program may not reimburse a reinsuring carrier with respect to the claims of a reinsured
17 employee or dependent until the carrier has incurred an initial level of claims for the employee or
18 dependent of \$5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring
19 carrier is responsible for 20% of the next \$100,000 of benefit payments during a calendar year and the
20 program shall reinsure the remainder. A reinsuring carrier's liability under this subsection (4)(d)(i) may not
21 exceed a maximum limit of \$25,000 in any calendar year with respect to any reinsured individual.

22 (ii) The board annually shall adjust the initial level of claims and maximum limit to be retained by
23 the carrier to reflect increases in costs and utilization within the standard market for health benefit plans
24 within the state. The adjustment may not be less than the annual change in the medical component of
25 the consumer price index for all urban consumers of the United States department of labor, bureau of
26 labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor.

27 (e) A small employer carrier may terminate reinsurance with the program for one or more of the
28 reinsured employees or dependents of a small employer on any anniversary of the health benefit plan.

29 (f) A small employer group health benefit plan in effect before January 1, 1994, may not be
30 reinsured by the program until the board determines that sufficient funding sources are available.

(g) A reinsuring carrier shall apply all managed care and claims-handling techniques, including utilization review, individual case management, preferred provider provisions, and other managed care provisions or methods of operation, consistently with respect to reinsured and nonreinsured business.

(5) (a) As part of the plan of operation, the board shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology must provide for the development of base reinsurance premium rates that must be multiplied by the factors set forth in subsection (5)(b) to determine the premium rates for the program. The base reinsurance premium rates must be established by the board, subject to the approval of the commissioner, and must be set at levels that reasonably approximate the premiums necessary to recover one-half of the expenses for the calendar year. For purposes of this section, expenses include administrative expenses and the actuarially anticipated claims to be incurred, adjusted to reflect retention levels required under this part.

(b) Premiums for the program are as follows:

(i) An entire small employer group may be reinsured for a rate that is one and one-half times the base reinsurance premium rate for the group established pursuant to this subsection (5).

(ii) An eligible employee or dependent may be reinsured for a rate that is five times the base reinsurance premium rate for the individual established pursuant to this subsection (5).

(c) The board shall annually review the methodology established under subsection (5)(a), including the system of classification and any rating factors, to ensure that it is actuarially sound and that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology that are subject to the approval of the commissioner.

(d) The board may consider adjustments to the premium rates charged by the program to reflect the use of effective cost containment and managed care arrangements.

(6) If a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must meet the requirements relating to premium rates set forth in 33-22-1809.

(7) (a) ~~Before March 1 of each year~~ Annually, the board shall determine and report to the commissioner the program net loss for the previous calendar year, including administrative expenses and

1 incurred losses for the year, taking into account investment income and other appropriate gains and
2 losses, and the actuarially anticipated losses for the calendar year. The sum of board may assess carriers
3 to cover the program net loss for the previous calendar year, plus one-half of the actuarially anticipated
4 claims to be incurred during the current calendar year, and one-half of anticipated administrative expenses
5 during the current calendar year must equal the total assessment amount to the extent that these costs
6 cannot be paid by projected income from premiums and other sources.

7 (b) (i) Each assessable carrier shall share in the program in an amount determined by multiplying
8 the total assessment amount by a fraction, the numerator of which is the number of individuals in this
9 state covered under disability insurance by the assessable carrier and the denominator of which is the
10 number of all individuals in this state covered under disability insurance by all assessable carriers.

11 (ii) The board shall make a reasonable effort to ensure that each insured individual is counted only
12 once for the purpose of assessment. The board shall require each assessable carrier that provides excess
13 of loss or stop loss insurance to include in its count of insured individuals all individuals whose coverage
14 is reinsured in whole or in part, including coverage under excess of loss or stop loss insurance. The board
15 shall allow an assessable carrier who is an excess of loss or stop loss insurer to exclude from its count
16 of insured individuals those who have been counted by a primary disability insurer or by a primary
17 reinsurer.

18 (iii) The board may use any reasonable method of estimating the number of individuals insured by
19 an assessable carrier if the specific number is unknown.

20 (c) The board shall make an annual determination in accordance with this section of each
21 assessable carrier's liability for its share of the contribution to the program and, except as otherwise
22 provided by this section, make an annual assessment against each assessable carrier to the extent of that
23 liability. Payment of an assessment is due within 30 days of receipt by the assessable carrier of written
24 notice of the assessment. An assessable carrier that ceases doing business within the state is liable for
25 assessments until the end of the calendar year in which the assessable carrier ceased doing business. The
26 board may determine not to assess an assessable carrier if the assessable carrier's liability determined
27 in accordance with this section does not exceed \$10.

28 (d) The board may establish and maintain program reserves not to exceed five times the
29 actuarially anticipated losses for the calendar year.

30 (e) If the sum of the reinsurance premiums and assessments in any calendar year exceeds the

1 sum of the administrative expenses and incurred claims for that year, the board may proportionately credit
2 the excess to assessable carriers or it may place the excess in program reserves, subject to the limits in
3 subsection (7)(d).

4 (8) The participation in the program as reinsuring carriers; the establishment of rates, forms, or
5 procedures; or any other joint collective action required by this part may not be the basis of any legal
6 action, criminal or civil liability, or penalty against the program or any of its reinsuring carriers, either
7 jointly or separately.

8 (9) The board, as part of the plan of operation, shall develop standards setting forth the minimum
9 levels of compensation to be paid to producers for the sale of basic and standard health benefit plans. In
10 establishing the standards, the board shall take into consideration the need to ensure the broad availability
11 of coverages, the objectives of the program, the time and effort expended in placing the coverage, the
12 need to provide ongoing service to small employers, the levels of compensation currently used in the
13 industry, and the overall costs of coverage to small employers selecting these plans.

14 (10) The program is exempt from taxation.

15 (11) On or before July 1 of each year, the commissioner shall evaluate the operation of the
16 program and report to the governor and the legislature in writing the results of the evaluation. The report
17 must include an estimate of future costs of the program, assessments necessary to pay those costs, the
18 appropriateness of premiums charged by the program, the level of insurance retention under the program,
19 the cost of coverage of small employers, and any recommendations for change to the plan of operation.

20 (12) All premiums and other money paid to the small employer carrier reinsurance program and
21 all property and securities acquired through the use of money and interest and dividends earned on money
22 belonging to the small employer carrier reinsurance program are solely the property of the program and
23 must be used exclusively for the operations and obligations of the program. Money collected by the
24 program is not subject to legislative appropriation."
25

26 **Section 56. Section 33-30-102, MCA, is amended to read:**

27 **"33-30-102. Application of this chapter -- construction of other related laws. (1) All health service**
28 **corporations are subject to the provisions of this chapter. In addition to the provisions contained in this**
29 **chapter, other chapters and provisions of this title apply to health service corporations as follows:**
30 **33-2-502; 33-3-308; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 17, parts 2 and 10**

through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."

Section 57. Section 33-30-107, MCA, is amended to read:

"33-30-107. Annual statement. (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on ~~form No. 13~~ the N.A.I.C. health blank form with the commissioner of insurance. This annual statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions. The statement must be accompanied by an actuarial opinion attesting to the insurer's reserves.

(2) The health service corporation shall file a statement containing any other information concerning its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic ~~diskette~~ versions of its annual and quarterly financial statements with the national association of insurance commissioners. The ~~filing~~ date for submission of the annual statement ~~diskette~~ electronic filing is March 1. The ~~filing~~ dates for the ~~other three submission of the quarterly statements~~ statement electronic filing are as follows:

(i) the first quarter ~~statement~~ filing is due May 15;

(ii) the second quarter ~~statement~~ filing is due August 15; and

(iii) the third quarter ~~statement~~ filing is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements.

(4) The commissioner may, after notice and hearing, suspend or revoke a health service corporation's license or impose a fine not to exceed \$100 a day and not to exceed \$1,000 upon a health service corporation that fails to file an annual statement as required by this part."

Section 58. Section 33-30-201, MCA, is amended to read:

"33-30-201. Reserves -- requirements suspended. (1) The corporation shall maintain at all times unobligated funds adequate to:

(a) provide the hospital, medical-surgical, and other health services made available to its members

1 and beneficiaries; and

2 (b) meet all costs and expenses.

3 (2) In addition, reserves of a health service corporation in cash, certificates of deposit, obligations
4 issued or guaranteed by the government of the United States, or other assets approved by the
5 commissioner ~~shall~~ must be maintained in an amount not less than:

6 (a) \$500,000; or, if licensed under this chapter after October 1, 1999, \$750,000; or

7 (b) an amount equal to 1 month's average income from dues or fees paid to the corporation by
8 its members or beneficiaries, based on an average of the preceding 12 months, whichever is less.

9 ~~(3) If the reserves are not equal to the average in subsection (2)(b), they must have been~~
10 ~~increased during the preceding 12 months by an amount equal to 1% of the gross dues or fee income~~
11 ~~during that period.~~

12 ~~(4)(3)~~ The determination of minimum reserves is subject, as to amounts payable to participating
13 providers of the health services, to any right of the corporation to prorate the amounts under the terms
14 of its health service contracts with providers.

15 ~~(5) The commissioner may decrease or suspend the requirements of this section if he finds that~~
16 ~~the action is in the best interest of the members of the corporation."~~

17
18 **Section 59. Section 33-31-111, MCA, is amended to read:**

19 **"33-31-111. Statutory construction and relationship to other laws. (1)** Except as otherwise
20 provided in this chapter, the insurance or health service corporation laws do not apply to any health
21 maintenance organization authorized to transact business under this chapter. This provision does not apply
22 to an insurer or health service corporation licensed and regulated pursuant to the insurance or health
23 service corporation laws of this state except with respect to its health maintenance organization activities
24 authorized and regulated pursuant to this chapter.

25 (2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority
26 or its representatives is not a violation of any law relating to solicitation or advertising by health
27 professionals.

28 (3) A health maintenance organization authorized under this chapter is not practicing medicine
29 and is exempt from Title 37, chapter 3, relating to the practice of medicine.

30 (4) This chapter does not exempt a health maintenance organization from the applicable

1 certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

2 (5) This section does not exempt a health maintenance organization from the prohibition of
3 pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701
4 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of
5 33-3-308 and 33-3-701 through 33-3-704.

6 (6) This section does not exempt a health maintenance organization from:

7 (a) prohibitions against interference with certain communications as provided under chapter 1,
8 part 8;

9 (b) the provisions of Title 33, chapter 22, part 19;

10 (c) the requirements of 33-22-134 and 33-22-135; or

11 (d) network adequacy and quality assurance requirements provided under chapter 36.

12 (7) ~~Sections~~ Chapter 1, parts 12 and 13, of this title, 33-3-431, 33-15-308, 33-22-141,
13 33-22-142, 33-22-246, 33-22-247, 33-22-514, 33-22-523, 33-22-524, and 33-22-526 apply to health
14 maintenance organizations."

15
16 **Section 60.** Section 33-31-202, MCA, is amended to read:

17 **"33-31-202. Issuance of certificate of authority.** (1) The commissioner shall issue or deny a
18 certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after
19 receipt of the application. The commissioner shall grant a certificate of authority upon payment of the
20 application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following
21 conditions is met:

22 (a) The persons responsible for the conduct of the applicant's affairs are competent and
23 trustworthy.

24 (b) The health maintenance organization will effectively provide or arrange for the provision of
25 basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of
26 reasonable requirements for copayments. This requirement does not apply to the health care services
27 provided by a health maintenance organization to a person receiving medicaid services under the Montana
28 medicaid program as established in Title 53, chapter 6.

29 (c) The health maintenance organization is financially responsible and can reasonably be expected
30 to meet its obligations to enrollees and prospective enrollees. In making this determination, the

1 commissioner may consider:

2 (i) the financial soundness of the arrangements for health care services and the schedule of
3 charges used in connection with the services;

4 (ii) the adequacy of working capital;

5 (iii) any agreement with an insurer, a health service corporation, a government, or any other
6 organization for ensuring the payment of the cost of health care services or the provision for automatic
7 applicability of an alternative coverage in the event of discontinuance of the health maintenance
8 organization;

9 (iv) any agreement with providers for the provision of health care services;

10 (v) any deposit of cash or securities submitted in accordance with 33-31-216; and

11 (vi) any additional information that the commissioner may reasonably require.

12 (d) The enrollees must be afforded an opportunity to participate in matters of policy and operation
13 pursuant to 33-31-222.

14 (e) Nothing in the proposed method of operation, as shown by the information submitted pursuant
15 to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by
16 the commissioner.

17 (2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404
18 are complied with.

19 (3) The commissioner shall examine each health maintenance organization applying for an initial
20 certificate of authority to do business in this state. In lieu of making an examination under this part of any
21 health maintenance organization domiciled in another state, the commissioner may accept an examination
22 report on the organization prepared by the insurance department of the organization's state of domicile."
23

24 **Section 61. Section 33-31-211, MCA, is amended to read:**

25 **"33-31-211. Annual statements -- revocation for failure to file -- penalty for false swearing. (1)**

26 Unless it is operated by an insurer or a health service corporation as a plan, each authorized health
27 maintenance organization shall annually on or before March 1 file with the commissioner a full and true
28 statement of its financial condition, transactions, and affairs as of the preceding December 31. The
29 statement must be in the general form and content required by the commissioner and must be completed
30 in accordance with the national association of insurance commissioners' annual statement instructions.

1 The statement must be verified by the oath of at least two principal officers of the health maintenance
2 organization. The commissioner may waive any verification under oath. In addition, a health maintenance
3 organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually
4 file on or before June 1 an audited financial statement. A health maintenance organization's audited
5 financial statement must comply with rules adopted by the commissioner concerning audited financial
6 statements.

7 (2) At the time of filing the annual statement required by March 1, the health maintenance
8 organization shall pay the commissioner the fee for filing the statement as prescribed in 33-31-212. The
9 commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as
10 provided in 33-31-212, may impose a penalty of \$100, or may suspend or revoke the certificate of
11 authority of a health maintenance organization that fails to file an annual statement when due. Each day
12 that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may
13 not exceed \$1,000.

14 (3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 for each
15 violation upon a director, officer, partner, member, insurance producer, or employee of a health
16 maintenance organization who knowingly subscribes to or concurs in making or publishing an annual
17 statement required by law that contains a material statement that is false.

18 (4) The commissioner may require reports considered reasonably necessary and appropriate to
19 enable the commissioner to carry out the duties required of the commissioner under this chapter, including
20 but not limited to a statement of operations, transactions, and affairs of a health maintenance
21 organization operated by an insurer or a health service corporation as a plan."

22
23 **Section 62. Section 33-31-216, MCA, is amended to read:**

24 **"33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7),**
25 **each authorized health maintenance organization shall deposit with the commissioner cash, securities, or**
26 **any combination of cash or securities acceptable to the commissioner in the amount set forth in this**
27 **section.**

28 (2) The amount of the deposit for a health maintenance organization during the first year of its
29 operation is \$200,000.

30 (3) At the beginning of each succeeding year, unless not applicable, the health maintenance

1 organization shall deposit with the commissioner cash, securities, or any combination of cash or securities
2 acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered
3 expenditures for that year.

4 (4) Unless not applicable, a health maintenance organization that is in operation on October 1,
5 1987, shall make a deposit equal to the greater of:

6 (a) 1% of the preceding 12 months' uncovered expenditures; or

7 (b) 4% of its estimated annual uncovered expenditures for each year.

8 (5) The commissioner may waive any of the deposit requirements set forth in subsections (1)
9 through (4) whenever the commissioner is satisfied that:

10 (a) the health maintenance organization has sufficient net worth and an adequate history of
11 generating net income to ensure its financial viability for the next year;

12 (b) the health maintenance organization's performance and obligations are guaranteed by an
13 organization with sufficient net worth and an adequate history of generating net income; or

14 (c) the health maintenance organization's assets or its contracts with insurers, health service
15 corporations, governments, or other organizations are reasonably sufficient to ~~assure~~ ensure the
16 performance of its obligations.

17 (6) When a health maintenance organization achieves a net worth not including land, buildings,
18 and equipment of at least \$1 million or achieves a net worth including organization-related land, buildings,
19 and equipment of at least \$5 million, the annual deposit requirement under subsection (3) does not apply.
20 The annual deposit requirement under subsection (3) does not apply to a health maintenance organization
21 if the total amount of the accumulated deposit is greater than the capital requirement for the formation
22 or admittance of a disability insurer in this state. If the health maintenance organization has a
23 guaranteeing organization that has been in operation for at least 5 years and has a net worth not including
24 land, buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years
25 and has a net worth including organization-related land, buildings, and equipment of at least \$5 million,
26 the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is
27 sponsoring more than one health maintenance organization, however, the net worth requirement is
28 increased by a multiple equal to the number of those health maintenance organizations. This requirement
29 to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any
30 time that the guaranteeing organization maintains for each health maintenance organization it sponsors

1 a net worth at least equal to the capital and surplus requirements for a disability insurer.

2 (7) All income from deposits belongs to the depositing health maintenance organization and must
3 be paid to it as it becomes available. A health maintenance organization that has made a securities deposit
4 may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any
5 combination of cash or securities of equal amount and value. A health maintenance organization may not
6 substitute securities without prior approval by the commissioner.

7 (8) In any year in which an annual deposit is not required of a health maintenance organization,
8 at the health maintenance organization's request, the commissioner shall reduce the previously
9 accumulated deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows
10 the health maintenance organization to be exempt from the annual deposit requirement. If the amount of
11 net worth no longer supports a reduction of its required deposit, the health maintenance organization shall
12 immediately redeposit \$100,000 for each \$250,000 of reduction in net worth. However, the health
13 maintenance organization's total deposit may not be required to exceed the maximum required under this
14 section.

15 (9) (a) Unless Subject to subsection (9)(b) and unless it is operated by an insurer or a health
16 service corporation as a plan, each health maintenance organization must have a minimum capital of at
17 least \$200,000 in addition to any deposit requirements under this section. The capital account must be
18 in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or
19 securities acceptable to the commissioner.

20 (b) A health maintenance organization licensed under this chapter after October 1, 1999, must
21 have a minimum capital of at least \$750,000. The amount required to be deposited with the
22 commissioner under subsection (2) must be included in the calculation of the capital needed to meet the
23 \$750,000 minimum.

24 (10) Each health maintenance organization shall demonstrate that if it becomes insolvent:

25 (a) enrollees hospitalized on the date of insolvency will be covered until discharged; and

26 (b) enrollees will be entitled to similar alternate insurance coverage that does not contain any
27 medical underwriting or preexisting limitation requirements."

28
29 Section 63. Section 33-31-301, MCA, is amended to read:

30 "33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each

1 enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization
2 shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance
3 policy issued by an insurer or a contract issued by a health service corporation, whether by option or
4 otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

5 (2) A health maintenance organization may not issue or deliver an enrollment form, an evidence
6 of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this
7 state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved
8 enrollment form or evidence of coverage is filed with and approved by the commissioner.

9 (3) An evidence of coverage issued or delivered to a person resident in this state may not contain
10 a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence
11 of coverage must contain:

12 (a) a clear and concise statement, if a contract, or a reasonably complete summary, if a
13 certificate, of:

14 (i) the health care services and the insurance or other benefits, if any, to which the enrollee is
15 entitled;

16 (ii) any limitations on the services, kinds of services, or benefits to be provided, including any
17 deductible or copayment feature;

18 (iii) the location at which and the manner in which information is available as to how services may
19 be obtained;

20 (iv) the total amount of payment for health care services and the indemnity or service benefits,
21 if any, that the enrollee is obligated to pay with respect to individual contracts; and

22 (v) a clear and understandable description of the health maintenance organization's method for
23 resolving enrollee complaints;

24 (b) definitions of geographical service area, emergency care, urgent care, out-of-area services,
25 dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of
26 coverage and have an effect on the benefits covered by the plan. The definition of geographical service
27 area need not be stated in the text of the evidence of coverage if the definition is adequately described
28 in an attachment that is given to each enrollee along with the evidence of coverage.

29 (c) clear disclosure of each provision that limits benefits or access to service in the exclusions,
30 limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and

1 exceptions that must be disclosed include but are not limited to:

2 (i) emergency and urgent care;

3 (ii) restrictions on the selection of primary or referral providers;

4 (iii) restrictions on changing providers during the contract period;

5 (iv) out-of-pocket costs, including copayments and deductibles;

6 (v) charges for missed appointments or other administrative sanctions;

7 (vi) restrictions on access to care if copayments or other charges are not paid; and

8 (vii) any restrictions on coverage for dependents who do not reside in the service area.

9 (d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease
10 treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and
11 nervous and mental disorders;

12 (e) a provision requiring immediate accident and sickness coverage, from and after the moment
13 of birth, to each newborn infant of an enrollee or the enrollee's dependents;

14 (f) a provision providing coverage as required in 33-22-133;

15 (g) a provision requiring medical treatment and referral services to appropriate ancillary services
16 for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and
17 coverage provided in Title 33, chapter 22, part 7; however:

18 (i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary
19 services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not
20 limit the enrollee to a health maintenance organization provider for the treatment of and appropriate
21 ancillary services for mental illness, alcoholism, or drug addiction;

22 (ii) if an enrollee chooses a provider other than the health maintenance organization provider for
23 treatment and referral services, the enrollee's designated provider shall limit treatment and services to
24 the scope of the referral in order to receive payment from the health maintenance organization;

25 (iii) the amount paid by the health maintenance organization to the enrollee's designated provider
26 may not exceed the amount paid by the health maintenance organization to one of its providers for
27 equivalent treatment or services;

28 (iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided
29 under the Montana medicaid program as established in Title 53, chapter 6;

30 (h) a provision as follows:

1 "Conformity With State Statutes: Any provision of this evidence of coverage that on its effective
2 date is in conflict with the statutes of the state in which the insured resides on that date is amended to
3 conform to the minimum requirements of those statutes."

4 (i) a provision that the health maintenance organization shall issue, without evidence of
5 insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee,
6 dependents, or family members:

7 (ii) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members
8 covered under the evidence of coverage ceases because of termination of employment or termination of
9 membership in the class or classes eligible for coverage under the policy or because the employer
10 discontinues the business or the coverage;

11 (iii) if the enrollee had been enrolled in the health maintenance organization for a period of 3
12 months preceding the termination of group coverage; and

13 (iii) if the enrollee applied for continuing coverage within 31 days after the termination of group
14 coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by
15 the group contract from which the enrollee converts.

16 (j) a provision that clearly describes the amount of money an enrollee shall pay to the health
17 maintenance organization to be covered for basic health care services.

18 (4) A health maintenance organization may amend an enrollment form or an evidence of coverage
19 in a separate document if the separate document is filed with and approved by the commissioner and
20 issued to the enrollee.

21 (5) (a) A health maintenance organization shall provide the same coverage for newborn infants,
22 required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be
23 no waiting or elimination periods. A health maintenance organization may not assess a deductible or
24 reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in
25 benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

26 (b) A health maintenance organization may not issue or amend an evidence of coverage in this
27 state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and
28 sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the
29 moment of birth.

30 (c) If a health maintenance organization requires payment of a specific fee to provide coverage

of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

~~(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.~~

~~(7)(6)~~ The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

~~(8)(7)~~ The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 64. Section 33-31-401, MCA, is amended to read:

"33-31-401. Examination. (1) The commissioner may examine the affairs of a health maintenance organization as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make an examination at least once every 3 years. The provisions of 33-1-408 and 33-1-409 apply to examinations under this section.

(2) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner may administer oaths to and examine the officers and insurance producers of the health maintenance organization and the principals of the providers concerning their business.

(3) (a) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as

1 necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense
2 allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by
3 the commissioner. The commissioner may present an account periodically during the course of the
4 examination or at the termination of the examination as the commissioner considers proper. A person may
5 not pay and an examiner may not accept any additional emolument on account of any examination.

6 (b) If a health maintenance organization fails to pay the charges and expenses as referred to in
7 subsection (3)(a), the commissioner shall pay them out of the funds of the commissioner in the same
8 manner as other disbursements of funds. The amount ~~so paid must be~~ is a lien upon all of the person's
9 assets and property in this state and may be recovered by suit by the attorney general on behalf of the
10 state ~~of Montana~~ and restored to the appropriate fund.

11 (4) In lieu of an examination, the commissioner may accept the report of an examination made
12 by the commissioner of another state."

13
14 **Section 65.** Section 39-8-207, MCA, is amended to read:

15 **"39-8-207. Requirements of licensee.** (1) A professional employer organization or group shall, by
16 written contract with the client, establish the responsibilities and duties of each party. The contract must
17 disclose to the client:

18 (a) the services provided, the administrative fee, and the respective rights and obligations of the
19 parties;

20 (b) a statement providing that the professional employer organization or group:

21 (i) reserves a right of direction and control over employees assigned to the client's location. The
22 client may retain sufficient direction and control over employees necessary to conduct business and
23 without which the client would be unable to conduct business, discharge fiduciary responsibilities, or
24 comply with state licensing laws.

25 (ii) assumes responsibility for the payment of wages of employees, workers' compensation
26 premiums, payroll-related taxes, and employee benefits from its own accounts without regard to
27 payments by the client; and

28 (iii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right
29 to accept or cancel the assignment of an employee.

30 (c) a statement that, with respect to a worker supplied to a client by a professional employer

1 organization or group, the client shares joint and several liability for any wages, workers' compensation
2 premiums, and payroll-related taxes and for any benefits left unpaid by the professional employer
3 organization or group and that, in the event that the licensee's license is suspended or revoked, this
4 liability is retroactive to the client's entering into a contract with the licensee; and

5 (d) a statement that the client is responsible for compliance with the Montana Safety Culture Act,
6 Title 39, chapter 71, part 15.

7 (2) The professional employer organization or group shall:

8 (a) give written notice of the general nature of the relationship between the professional employer
9 organization or group and the client to each employee assigned to perform services at the client's place
10 of work. The disclosure must provide that the professional employer organization:

11 (i) reserves a right of direction and control over employees assigned to the client's location. The
12 client may retain sufficient direction and control over employees necessary to conduct business and
13 without which the client would be unable to conduct business, discharge fiduciary responsibilities, or
14 comply with state licensing laws.

15 (ii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right
16 to accept or cancel the assignment of an employee.

17 (b) submit to the department, within 90 days of the end of each calendar quarter, information
18 certified by an independent certified public accountant demonstrating that all payroll-related taxes for the
19 quarter have been paid. Upon a showing of reasonable cause, one 30-day extension may be granted for
20 each quarter.

21 (c) maintain and make available for the department or its agent all records relating to the
22 licensee's business conduct. Records must be maintained for 5 years after terminating an employee
23 leasing arrangement or professional employer arrangement.

24 (d) notify the department in writing within 20 days of a change of business address or a change
25 in partners, directors, officers, members, or controlling persons designated in the license;

26 (e) notify the department in writing within 20 days after a client either commences or terminates
27 a professional employer arrangement or an employee leasing arrangement with that professional employer
28 organization or group; and

29 (f) post the license issued in a conspicuous place in the principal place of business and display,
30 in clear public view in each licensee's office, a notice stating that the professional employer organization

1 or group is licensed and regulated by the department.

2 (3) When a professional employer organization or group uses a professional employer arrangement
3 with the client, both the professional employer organization or group and the client are the immediate
4 employers of the workers subject to the arrangement for the purposes of the workers' compensation laws
5 of this state. When a professional employer organization or group uses an employee leasing arrangement
6 with the client, the professional employer organization or group is the immediate employer of the workers
7 subject to the arrangement for the purposes of the workers' compensation laws of this state.

8 (4) A professional employer organization or group shall:

9 (a) pay wages and collect, report, and pay payroll-related taxes from its own accounts;

10 (b) pay unemployment taxes, pursuant to 39-51-1103, and provide, maintain, and secure all
11 records and documents required of employers under the unemployment insurance laws of this state. For
12 unemployment reporting purposes, each professional employer organization is the employing unit, as
13 defined in 39-51-201, and shall keep separate records and submit quarterly wage lists for each of its
14 clients.

15 (c) provide workers' compensation coverage for all employees and provide, maintain, and secure
16 all records and documents required of employers under the workers' compensation laws of this state. A
17 license may not be issued to a professional employer organization or group until the department receives
18 proof of workers' compensation coverage for all employees assigned to any client location in this state.

19 (5) A professional employer organization or group is the employer for sponsoring and maintaining
20 employee benefit and welfare plans. The plans, if limited to employees of the professional employer
21 organization or group, are not multiple employer welfare arrangements.

22 (6) A professional employer organization or group shall disclose to the department, to each client,
23 and to its employees information on any health or life fringe benefit program provided for its employees.
24 The information must include:

25 (a) the type of benefits;

26 (b) the identity of each insurer providing each type of coverage;

27 (c) the amount of benefits for each type of coverage and to whom or on whose behalf the
28 benefits will be paid;

29 (d) the policy limits on each insurance policy; and

30 (e) whether coverage is fully insured, partially insured, or fully self-funded.

(7) Disclosure required by this section may be made by any written means reasonably calculated to adequately inform the employees, including a summary plan description that meets the requirements of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, et seq.), as amended.

(8) (a) Subject to any contrary provisions of the contract between the client and the professional employer organization or group, the professional employer arrangement that exists between the parties must be interpreted for purposes of insurance, bonding, and employer liability pursuant to subsection (8)(b).

(b) The professional employer organization or group:

(i) is entitled, along with the client, to the exclusivity of the remedy under both the workers' compensation and employers' liability provisions of a workers' compensation policy or plan of either party; and

(ii) is not liable for the acts, errors, or omissions of a client or of an employee acting under the direction and control of a client, subject to the provisions of this chapter. Subject to the provisions of this chapter, a client is not liable for the acts, errors, or omissions of a professional employer organization or group or of any employee of a professional employer organization or group acting under the direction and control of the professional employer organization or group.

(9) A professional employer organization that applies for workers' compensation coverage shall also maintain and furnish to the insurer sufficient information to permit the calculation of an experience modification factor for each client employer, including but not limited to:

(a) the client employer's corporate or business name;

(b) the client employer's taxpayer or employer identification number;

(c) the client employer's risk identification number;

(d) a listing of all employees assigned to each client employer and the applicable classification code and payroll; and

(e) the client employer's first report of injury identifying the client employer and any other information necessary to permit the calculation of an experience modification factor for each client employer.

(10) An employee assigned to a client by a professional employer organization or group is considered the employee of the client for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, and liquor liability insurance carried by the client. An employee assigned to

a client by a professional employer organization or group is not an employee of the professional employer organization or group for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, or liquor liability insurance carried by the professional employer organization or group unless the employee is included by reference in an employment arrangement contract, insurance contract, or bond.

(11) The sale of professional employer services pursuant to this chapter does not constitute the sale of insurance under Title 33 unless the professional employer organization or group:

(a) undertakes to indemnify another or pay or provide a specified or determinable amount of benefit based on determinable contingencies unless done through a licensed insurer or an employee welfare benefit plan as defined in 29 U.S.C. 1002(1);

(b) solicits, negotiates, effects, procures, delivers, renews, continues, or binds an insurance policy unless done through a licensed insurance producer; or

(c) is not exempt under 33-17-103(4).

(12) A sole proprietor or a working member of a partnership working under a professional employer arrangement may not receive unemployment insurance benefits unless the individual would otherwise be entitled to benefits if the professional employer arrangement did not exist.

(13) If the professional employer organization or group or the client complies with the provisions of 39-71-401 with respect to a worker under the professional employer arrangement, the professional employer organization or group and the client, with respect to those workers, are not uninsured employers, as defined in 39-71-501, and are not subject to the provisions of 39-71-508 or 39-71-515."

Section 66. Section 61-12-303, MCA, is amended to read:

"61-12-303. Requirements for license. (1) The commissioner may not issue a license to a company until the company has filed ~~with him~~ the following:

(a) a formal application in ~~such the~~ form and detail ~~as that~~ the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in ~~such the~~ form and detail ~~as that~~ the commissioner may require, executed on oath by its president or other principal officer;

1 (e) a certificate from the commissioner that it has complied with 61-12-304 in all cases ~~where~~
2 in which a deposit of cash or a bond is required by this part;

3 (f) if the company is a corporation, a certificate from the ~~corporation commissioner~~ secretary of
4 ~~the state of Montana, in the event it be a corporation,~~ that it the company has complied with the
5 ~~corporation laws of said state~~ this state's corporate laws.

6 (2) The commissioner may not issue a license to a company until the company has paid to the
7 commissioner \$100 as an annual license fee; or the pro rata portion ~~thereof~~ of the \$100 necessary to be
8 paid to the end of the current calendar year from the date of the application for the license.

9 (3) The commissioner may not issue a license to a company until the company has satisfied him
10 by an examination and evidence that the commissioner may require, ~~in his discretion,~~ that the company
11 has complied with the laws of the state ~~of Montana,~~ and that its management is trustworthy and
12 competent, and that the company is financially responsible."

13
14 **NEW SECTION. Section 67. Service contract insurance.** (1) For the purposes of this section,
15 "service contract insurance" means a contract or agreement for separately stated consideration and for
16 a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the
17 repair, replacement, or maintenance of property. The purchase price of the property must be greater than
18 \$5,000.

19 (2) For the purposes of this section, a contract or agreement issued by the manufacturer or seller
20 of the property covered by the contract or agreement does not constitute service contract insurance and
21 does not have to comply with any other provision of this title.

22 (3) Service contract insurance does not include motor club services, as defined in 61-12-301, or
23 vehicle casualty insurance, as defined in 33-1-206.

24
25 **NEW SECTION. Section 68. Mechanical breakdown insurance.** (1) "Mechanical breakdown
26 insurance" means a policy, contract, or agreement issued by an authorized insurer that provides for the
27 repair, replacement, or service for the operational or structural failure of the property because of a defect
28 in materials or workmanship or because of normal wear and tear.

29 (2) The term does not include motor club services, as defined in 61-12-301, or vehicle casualty
30 insurance, as defined in 33-1-206.

1
2 **NEW SECTION.** Section 69. Prepaid legal plan. (1) For the purposes of this section, "prepaid legal
3 plan" means the assumption of a contractual obligation that is to be spread directly or indirectly among
4 a group of persons to provide specified legal services or reimbursement for legal expenses in consideration
5 of a specified payment for an interval of time, regardless of whether the payment is made by the
6 beneficiary or by a third person on behalf of the beneficiary.

7 (2) A prepaid legal plan does not include the provision of or reimbursement for legal services that
8 are incidental to other insurance coverage. The following are not prepaid legal plans:

9 (a) retainer contracts made with individual clients with fees based on estimates of the nature and
10 amount of services that will be required;

11 (b) contracts made with a group of clients involved in the same or closely related legal matters;

12 (c) plans providing only a referral service or a discount card for legal services;

13 (d) legal services provided by unions or employee associations to members pertaining to
14 employment or occupation; or

15 (e) legal services provided by an agency of state or federal government to employees.
16

17 **NEW SECTION.** Section 70. Repealer. Sections 33-2-1311, 33-7-526, 33-22-801, 33-22-802,
18 33-22-803, 33-22-804, 33-22-805, 33-22-806, 33-22-811, 33-22-812, 33-22-813, 33-22-814,
19 33-22-815, and 33-22-816, MCA, are repealed.
20

21 **NEW SECTION.** Section 71. Codification instruction. [Sections 67 through 69] are intended to
22 be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part
23 2, apply to [sections 67 through 69].
24

25 **NEW SECTION.** Section 72. Severability. If a part of [this act] is invalid, all valid parts that are
26 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its
27 applications, the part remains in effect in all valid applications that are severable from the invalid
28 applications.
29

30 **NEW SECTION.** Section 73. Saving clause. [This act] does not affect rights and duties that

1 matured, penalties that were incurred, or proceedings that were begun before [the effective date of this
2 act].

3
4 NEW SECTION. Section 74. Effective dates. (1) Except as provided in subsection (2), [this act]
5 is effective October 1, 1999.

6 (2) [Sections 1 through 4 and 71 through 73 and this section] are effective on passage and
7 approval.

8 - END -

FISCAL NOTE

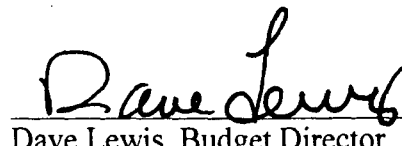
Bill #: HB0100

Title: Generally revise insurance and security laws

Primary Sponsor: Bruce Simon

Status: As introduced


Sponsor signature _____ Date _____

 1.7.99
Dave Lewis, Budget Director _____ Date _____

Fiscal Summary

	<u>FY2000 Difference</u>	<u>FY2001 Difference</u>
Expenditures:	\$0	\$0
Revenue:	\$0	\$0
Net Impact on General Fund Balance:	\$0	\$0

<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>	
	X	Significant Local Gov. Impact		X	Technical Concerns
	X	Included in the Executive Budget		X	Significant Long-Term Impacts

Fiscal Analysis

ASSUMPTIONS:

1. This is the general house cleaning bill for the State Auditor's Office. This bill revises both the insurance laws and the security laws. There is no fiscal impact associated with this bill.

HB 100 105

INDEX TO BILLS IN COMMITTEE

June 30, 1999

- Committee: (H) Business and Labor -

01:05 PM

HB 100 SPONSOR: Simon, Bruce SHORT TITLE: Generally revise laws administered by the state auditor**BY REQUEST OF: State Auditor****REFERRED ON: 12/23/1998 HEARD ON: 01/11/1999****EXECUTIVE ACTION: 02/18/1999 Bill Passed as Amended -- VOTE: 16 - 2****TABLED ON: 01/11/1999****FINAL DISPOSITION 04/29/1999 Chapter Number Assigned**

HB 101 SPONSOR: Bookout-Reinicke, Sylvia SHORT TITLE: Revise Board of Plumbers membership**BY REQUEST OF: Department Of Environmental Quality****BY REQUEST OF: Department Of Public Health And Human Services****REFERRED ON: 12/23/1998 HEARD ON: 01/11/1999****EXECUTIVE ACTION: 01/11/1999 Bill Passed -- VOTE: 18 - 0****FINAL DISPOSITION 03/16/1999 Chapter Number Assigned**

HB 109 SPONSOR: Mercer, John SHORT TITLE: Allow Dept of Justice automated video gambling, accounting and reporting system**BY REQUEST OF: Department Of Justice****REFERRED ON: 12/23/1998 HEARD ON: 01/12/1999****EXECUTIVE ACTION: 01/12/1999 Bill Passed as Amended -- VOTE: 18 - 0****FINAL DISPOSITION 04/23/1999 Chapter Number Assigned**

HB 112 SPONSOR: Hedges, Donald SHORT TITLE: Fines for cosmetology inspection violations**BY REQUEST OF: Board Of Cosmetologists****REFERRED ON: 12/23/1998 HEARD ON: 01/11/1999****TABLED ON: 01/11/1999****FINAL DISPOSITION 03/31/1999 (H) Missed Deadline for Revenue Bill Transmittal**

HB 121 SPONSOR: Krenzler, Billie SHORT TITLE: Pyramid scheme prohibition and establishing criminal penalties**BY REQUEST OF: State Auditor****REFERRED ON: 01/04/1999 HEARD ON: 01/20/1999****EXECUTIVE ACTION: 01/26/1999 Bill Passed as Amended -- VOTE: 18 - 0****FINAL DISPOSITION 03/17/1999 Chapter Number Assigned**

287

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 56th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS AND LABOR

Call to Order: By CHAIRMAN BRUCE SIMON, on January 11, 1999 at
800 A.M., in Room 104 Capitol.

ROLL CALL

Members Present:

Rep. Bruce Simon, Chairman (R)
Rep. Bob Pavlovich, Vice Chairman (D)
Rep. Paul Sliter, Vice Chairman (R)
Rep. Joe Barnett (R)
Rep. Rod Bitney (R)
Rep. Sylvia Bookout-Reinicke (R)
Rep. Roy Brown (R)
Rep. David Ewer (D)
Rep. Carol C. Juneau (D)
Rep. Billie Krenzler (D)
Rep. Bob Lawson (R)
Rep. Gay Ann Masolo (R)
Rep. Gary Matthews (D)
Rep. Joe McKenney (R)
Rep. Carolyn Squires (D)
Rep. Jay Stovall (R)
Rep. Cliff Trexler (R)
Rep. Carley Tuss (D)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 43,98,100,101,112-1/5/99
Executive Action: HB 112,100,101,88,31

John Forken, MT Plumbers and Pipefitters Union

{Tape : 1; Side : B; Approx. Time Counter : 400 - 416}

Tim Coleman, Board of Plumbers member

{Tape : 1; Side : B; Approx. Time Counter : 416 - 472}

Stuart Doggett, Montana Manufactured Housing

{Tape : 1; Side : B; Approx. Time Counter : 472 - 500}

Opponents:

Gene Fenderson, AFL-CIO

{Tape : 2; Side : A; Approx. Time Counter : 0 - 16}

Alec Hanson, Mt. League of Town and Cities

{Tape : 2; Side : A; Approx. Time Counter : 16 - 55}

Questions from Committee Members and Responses:

Rep. Stovall questions Steinmetz

{Tape : 2; Side : A; Approx. Time Counter : 55 - 141}

Rep. Krenzler questions Steinmetz

{Tape : 2; Side : A; Approx. Time Counter : 141 - 150}

Rep. Bitney questions Steinmetz

{Tape : 2; Side : A; Approx. Time Counter : 150 - 204}

Rep. Ewer questions Rep. Simon

{Tape : 2; Side : A; Approx. Time Counter : 204 - 314}

Reps. Stovall and Krenzler questions Rep. Simon

{Tape : 2; Side : A; Approx. Time Counter : 314 - 411}

Closing by Sponsor: Rep. Simon closed HB 98.

{Tape : 2; Side : A; Approx. Time Counter : 411 - 500}

HEARING ON HB 100

Sponsor: Rep. Simon, HD 18 introduced HB 100.

{Tape : 2; Side : B; Approx. Time Counter : 0 - 11}

Proponents: Frank Cote, Deputy Commission of Insurance, State Auditor Office.

{Tape : 2; Side : B; Approx. Time Counter : 11 - 54}

David Dennis-D A Davidson Company employee
{Tape : 2; Side : B; Approx. Time Counter : 54 - 67}

Steve Turkowitz, MT Auto Dealers Assn.
{Tape : 2; Side : B; Approx. Time Counter : 67 - 73}

John Cadby, MT Bankers Assn.
{Tape : 2; Side : B; Approx. Time Counter : 73 - 80}

Mr. Ward Shanahan, Helena attorney. EXHIBIT(9)
{Tape : 2; Side : B; Approx. Time Counter : 80 - 87}

Don Allen, Montana Medical Benefit Plan
{Tape : 2; Side : B; Approx. Time Counter : 87 - 136}

Greg Van Horrsen, State Farm Insurance and American Insurance Assn.
{Tape : 2; Side : B; Approx. Time Counter : 136 - 146}

Roger McGlen, Ex. Dir. Montana Insurance Agents of MT
{Tape : 2; Side : B; Approx. Time Counter : 146 - 150}

Mark Baker, American Council of Life Insurers.
{Tape : 2; Side : B; Approx. Time Counter : 150 - 167}

Opponents: None

Questions from Committee Members and Responses:

Rep. Sliter questions Frank Cote.
{Tape : 2; Side : B; Approx. Time Counter : 167 - 198}

Closing by Sponsor: Rep. Simon closed HB 100.
{Tape : 2; Side : B; Approx. Time Counter : 198 - 210}

HEARING ON HB 43

Sponsor: Rep. Pavlovich, HD 37 introduced HB 43.
{Tape : 2; Side : B; Approx. Time Counter : 210 - 438}

Proponents: None

Opponents: Jim Opperdahl, Dept of Justice.
{Tape : 2; Side : B; Approx. Time Counter : 438 - 500}

Ellen Angstad, Don't Gamble with the Future. EXHIBIT(11)
{Tape : 3; Side : A; Approx. Time Counter : 0 - 70}

Questions from Committee Members and Responses:

Rep. Stovall questions Rep. Pavlovich

{Tape : 3; Side : A; Approx. Time Counter : 70 - 110}

Rep. Simon questions Jim Opperdahl

{Tape : 3; Side : A; Approx. Time Counter : 110 - 120}

Rep. Bookout questions Jim Opperdahl

{Tape : 3; Side : A; Approx. Time Counter : 120 - 142}

Closing by Sponsor: Rep. Pavlovich closed HB 43.

{Tape : 3; Side : A; Approx. Time Counter : 142 - 143}

Mr. Lund, rancher from Miles City testified about the problems with the Building Codes. Lund came on the wrong day and his testimony is for the following Monday. Reps. Bookout, Stovall, Ewer, Sliter, and Squires questions Lund.

{Tape : 3; Side : A; Approx. Time Counter : 143 - 444}

EXECUTIVE ACTION ON HB 100

Motion/Vote: Rep. Pavlovich moved that HB 100 be tabled. Motion carried 18-0. EXHIBIT(10)

{Tape : 2; Side : B; Approx. Time Counter : 198 - 210}

EXECUTIVE ACTION ON HB 101

Motion/Vote: REP. BOOKOUT-REINICKE moved that HB 101 DO PASS.

Motion carried unanimously.

{Tape : 3; Side : A; Approx. Time Counter : 210 - 444}

EXECUTIVE ACTION ON HB 112

Motion/Vote: REP. SQUIRES moved that HB 112 DO PASS. Motion failed 1-17 with Squires voting aye.

{Tape : 3; Side : A; Approx. Time Counter : 444 - 500; Comments : on to tape 3-B at 70}

Substitute Motion/Vote: Rep. Pavlovich made a substitute motion that HB 112 be tabled. Substitute motion carried unanimously.

{Tape : 3; Side : B; Approx. Time Counter : 70 - 88}

HOUSE OF REPRESENTATIVES

BUSINESS AND LABOR COMMITTEE

ROLL CALL

DATE 1/11/99

NAME	PRESENT	ABSENT	EXCUSED
Chairman Bruce Simon	X		
Rep. Paul Sliter	X		
Rep. Bob Pavlovich	X		
Rep. Joe Barnett	X		
Rep. Rod Bitney	X		
Rep. Sylvia Bookout-Reineke	X		
Rep. Roy Brown	X		
Rep. David Ewer	X		
Rep. Billie Krenzler	X		
Rep. Bob Lawson	X		
Rep. Gay Ann Masolo	X		
Rep. Gary Matthews	X		
Rep. Joe McKenney	X		
Rep. Carolyn Squires	X		
Rep. Jay Stovall	X		
Rep. Carley Tuss	X		
Rep. Carol Juneau	X		
Rep. Cliff Trexler	X		

EXHIBIT 9
DATE 1/11/99
HB 100

**STATEMENT IN SUPPORT OF HB 100
BY THE INVESTMENT COMPANY INSTITUTE
1999 Montana Legislative Session**

Mr. Chairman and Members of the House Committee on Business and Labor:

My name is Ward Shanahan, I live in Helena and I represent the Investment Company Institute. The Institute is a Non-Profit Organization headquartered at 1401 H Street NW in Washington D.C. which serves the mutual fund industry. Therefore it has an on-going interest in both federal and state securities laws and regulations adopted pursuant to them.

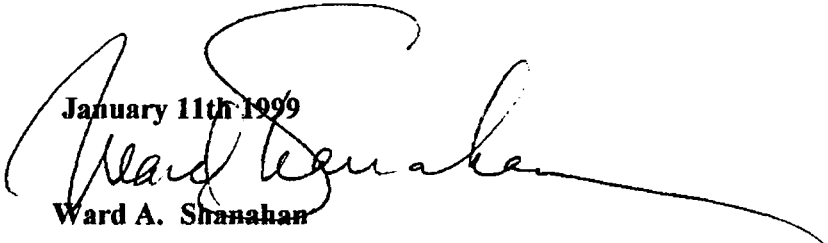
HB 100 (the Introduced Bill) which generally revises the laws administered by the State Auditor contains a number of changes to the Securities laws of Montana. The Institute has been working on this bill for several months with Deputy Commissioner O'Halloran and concurs in most of those changes and therefore generally supports the Securities Law changes in HB 100 (the Introduced Bill).

The National Securities Markets Improvement Act of 1996, (NSMIA), was adopted to help standardize Securities markets throughout the country and these amendments are necessary to bring Montana's securities laws into line with most of the laws of other states in this area and with applicable federal law.

We have also reviewed the most recent amendments offered by the Commissioner and concur in their addition to the bill.

Mr. Chairman, the Investment Company Institute recommends that the committee give the Securities laws changes in Introduced HB 100 and the proposed amendments a "DO PASS".

January 11th 1999


Ward A. Shanahan

**33 South Last Chance Gulch
P.O. Box 1715
Helena, MT 59624
Tel: 406-442-8560**

LEGISLATIVE AUDIT DIVISION

Scott A. Seacat, Legislative Auditor
John W. Northey, Legal Counsel
Tori Hunthausen, IT & Operations Manager



EXHIBIT 10
DATE 1/11/99
HB 100
Deputy Legislative Auditors:
Jim Pellegrini, Performance Audit
James Gillett, Financial-Compliance Audit

MEMORANDUM

January 6, 1999

TO: Representative Pavlovich
FROM: Jim Nelson, Performance Audit Manager
RE: Legislative Request 99L-490 - Sports Tabs

JN.

I contacted the Gambling Control Division and reviewed the MCAs for information on the taxation of sports tabs.

Laws Covering Sports Tabs

The 1997 legislature established a new license for sports tab game sellers. Prior to this, only licensed "manufacturers" could sell sports tabs. Manufacturers paid an annual license fee of \$1,000. Section 23-5-513, MCA, sets the annual license fee for a sports tab game seller at \$100. Section 23-5-502, MCA, requires a sports tab seller to collect, from the purchaser, a tax of \$1 for each 100 sports tabs sold.

Sports Tabs Taxes and License Fees

I collected information for the Gambling Control Division on sports tabs taxes and license fees for fiscal years 1991-92 through 1997-98. The following chart shows this information.

Sports Tab License Fees and Taxes			
Fiscal Year	License Fee	Tax	Total
1991-92	\$ 2,000	\$ 6,912	\$ 8,912
1992-93	1,000	2,592	3,592
1993-94	1,000	3,600	4,600
1994-95	1,000	4,176	5,176
1995-96	1,000	0	1,000
1996-97	0	859	859
1997-98	0	0	0
Total	\$ 6,000	\$ 18,139	\$ 24,139

There were no sports tab manufacturer licenses sold in fiscal year 1996-97. Fiscal year 1997-98 was the first year for the new sports tabs seller license. None of these were sold. In fiscal year 1996-97, the manufacturer that had been licensed in the prior year was allowed to sell his remaining stock of sports tabs for a processing fee of \$50 and the sports tabs tax. No sports tabs taxes have been collected since that time.

JN/t/99L-490

MONTANA HOUSE OF REPRESENTATIVES VISITORS REGISTER

DATE

1/11/99

BILL NO.

HB 100

SPONSOR(S)

Rep. Simon

TYPE

PROPONENT (P) OPPONENT (O) INFORMATIONAL (I)

PLEASE PRINT

PLEASE

CIRCLE

NAME

ADDRESS

REPRESENTING

☒ POI	MARK BAKER	HELENA	ACLI
☐ POI	Dwight Easton	Missoula	Farmers Ins
☐ POI	Jon McKeon	Helena	Farmers Ins.
☐ POI	Greg Van Housen	Helena	State Farm Ins.
☒ POI	with admit: Jacqueline Denmark	Helena	Am. Ind. Assn
☒ POI	Steve Turkiewicz	Helena	Mr. Auto Dealers Assn
☒ POI	Ward Shanahan	Helena	Investment Co. Trust
☒ POI	Roger McGlen	HELENA	ZIAM
☐ POI	Chuck Baker	Helena	BCBSMT
☒ POI	Frank Calk		J. Anderson
☐ POI	Don Allen	Helena	MMBP
☐ POI	Richard W Pratt	Helena	MT Agents Service
☐ POI	TOM Ebzery	Billings	YCHP
☐ POI			

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

LEGISLATIVE TAPE LOG

COMMITTEE:

House Bus & Station

DATE:

1/11/99

MINUTES

CONTENT NOTES

 Capes 2-a
 HB98

Clerking.

460 HB100
500 Capes 2-B
11 Prop ment.

Rep. Jansen RD18 Introduced
RD 100
House Clerking for Auditor
Govt. Rate - Deputy Ins
Commissioner
proponent

54

David Dennis - RDDO.
Employee
proponent

67

Steve Infowety - Mt Auto
Insurance Agent
proponent

73

John Cadby - Mt Jackson
proponent

80

Mr. Sharahan E 49
proponent

87

Ken Allen - Mt Med Ben
plan
proponent

136

Greg Van Vargen - Mt Jackson
Ins & Acc. Ins. Assn.
proponent

146

Greg McAllen - Mt Ins.
Agents of Mt.

LEGISLATIVE TAPE LOG

Pg 6

COMMITTEE:

House Labor & Labor

DATE:

1/11/99

MINUTES

Page 26

CONTENT NOTES

150

NB 100

Mark Baker - As Council of
State Ins.
Proposedno
opponents

no opponents - no information

167

no questions

State questions - late to
Mr. O'Halloran

191

Rep Dixon closed.

210

NB

100

Jacked

Rep Paulson moved to
table 100-
18-0

220

NB 43

Rep Paulson introduce
NB 43 - 14 H. 37-
Sponsor: J. Hill. Ex 10

438

no proponents

444 opponent

Jim Oppenheimer - Dept of Justice
opponent

445

Page 3-2

NB 43

Angela
Ellen "Angela" Donk Markle
with "The Future"
opponent. Ex 10

70

Paulson questioned by Heibel

AUGUST 2000

THE HISTORICAL SOCIETY ARCHIVES
RECEIVED FROM THE LEGISLATURE BLANK
TAPES FOR THESE MINUTES: HOUSE
BUSINESS & LABOR, FEBRUARY 12, 1999.

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 56th LEGISLATURE - REGULAR SESSION

COMMITTEE ON BUSINESS AND LABOR

Call to Order: By **CHAIRMAN BRUCE SIMON**, on February 12, 1999 at 8:00 A.M., in Room 104 Capitol.

ROLL CALL

Members Present:

Rep. Bruce Simon, Chairman (R)
Rep. Bob Pavlovich, Vice Chairman (D)
Rep. Paul Sliter, Vice Chairman (R)
Rep. Joe Barnett (R)
Rep. Rod Bitney (R)
Rep. Sylvia Bookout-Reinicke (R)
Rep. Roy Brown (R)
Rep. David Ewer (D)
Rep. Carol C. Juneau (D)
Rep. Billie Krenzler (D)
Rep. Bob Lawson (R)
Rep. Gay Ann Masolo (R)
Rep. Gary Matthews (D)
Rep. Joe McKenney (R)
Rep. Carolyn Squires (D)
Rep. Jay Stovall (R)
Rep. Cliff Trexler (R)
Rep. Carley Tuss (D)

Members Excused: None.

Members Absent: None.

Staff Present: Stephen Maly, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 581, HB 553, HJR 24, HB 557, HB 572, 2/10/1999
Executive Action: HB 557, HB 581, HJR 24, HB 100, HB 514, HB 526, HB 558, HB 556, HB 553, HB 497

HOUSE COMMITTEE ON BUSINESS AND LABOR

February 12, 1999

PAGE 5 of 8

Brian Earhardt, Bus Mgr.

{Tape : 2; Side : A; Approx. Time Counter : 406 - 486}

Jason Miller, LPIW

{Tape : 2; Side : A; Approx. Time Counter : 486 - 509}

Don Judge AFL-CIO

{Tape : 2; Side : A; Approx. Time Counter : 509 - 515}

{Tape : 2; Side : B; Approx. Time Counter : 0 - 23}

Jerry Driscoll, MT Building and Const Trades

{Tape : 2; Side : B; Approx. Time Counter : 23 - 51}

Opponents' Testimony: None

Informational Testimony: Kevin Braun, Dept. of Labor

{Tape : 2; Side : B; Approx. Time Counter : 51 - 92}

Questions from Committee Members and Responses: Rep. Ewer, Bookout, Juneau, Barnett, Stovall and Masolo question witnesses.

{Tape : 2; Side : B; Approx. Time Counter : 92 - 500}

{Tape : 3; Side : A; Approx. Time Counter : 0 - 103}

Closing by Sponsor: Rep. Squires closed.

{Tape : 3; Side : A; Approx. Time Counter : 103 - 163}

EXECUTIVE ACTION ON HB 100

Motion/Vote: REP. SIMON moved HB 100 be taken from table. Motion carried unanimously.

{Tape : 3; Side : A; Approx. Time Counter : 163 - 170}

Motion: REP. SIMON moved that HB 100 DO PASS.

Motion/Vote: REP. SIMON moved that HB 100 BE AMENDED. Motion carried 16-1 with Masolo voting no.

{Tape : 3; Side : A; Approx. Time Counter : 170 - 180}

Motion/Vote: REP. SIMON moved that HB 100 DO PASS AS AMENDED.

Motion carried 17-1 with Sliter voting no.

{Tape : 3; Side : A; Approx. Time Counter : 180 - 266}

EXECUTIVE ACTION ON HB 574

Motion: REP. MASOLO moved that HB 574 DO PASS.

{Tape : 3; Side : A; Approx. Time Counter : 266 - 272}

HOUSE OF REPRESENTATIVES

BUSINESS AND LABOR COMMITTEE

ROLL CALL

DATE 2/12/99

NAME	PRESENT	ABSENT	EXCUSED
Chairman Bruce Simon	X		
Rep. Paul Sliter	X		
Rep. Bob Pavlovich	X		
Rep. Joe Barnett	X		
Rep. Rod Bitney	X		
Rep. Sylvia Bookout-Reineke	X		
Rep. Roy Brown	X		
Rep. David Ewer	X		
Rep. Billie Krenzler	X		
Rep. Bob Lawson	X		
Rep. Gay Ann Masolo	X		
Rep. Gary Matthews	X		
Rep. Joe McKenney	X		
Rep. Carolyn Squires	X		
Rep. Jay Stovall	X		
Rep. Carley Tuss	X		
Rep. Carol Juneau	X		
Rep. Cliff Trexler	X		

pg. 5

Van Buren & Lee

2/12/99

CONTENT NOTES

Pape 2b
DB 572

James Dwyer - Dept of Labor
explanational witness -

Easy questions Quiscol

Boston " "
 Bureau " " Estabath.

Exce questions Given.

Barnett gestures. Pippy
 agrees. "Pippy"

Stovall questions Pepper.

Bennett ✓ ✓
Bookout ✓ Miller

Page 3a
QMB572

Masals question Ken Beam
Stewart Heaver

Rep. Agnew closed VB 5/2

Exp Code
QB/100

Seven do pass moose take
 HB100 Seven take 18-0
 Seven moose do pass HB100

Lenon moves spend next 14.2
 (17-0) (170) 16-1
 Lenon moves do past as ^{Mosale} 110

Amendment ¹⁷ ~~17~~ - 1 Shiteno

INDEX TO BILLS IN COMMITTEE

June 30, 1999

- Committee: (S) Business and Industry -

04:37 PM

-
- HB 32** **SPONSOR:** Johnson, Royal **SHORT TITLE:** Revise laws governing Board of Investments
 BY REQUEST OF: Department Of Commerce
 REFERRED ON: 01/27/1999 **HEARD ON:** 03/02/1999
 EXECUTIVE ACTION: 03/03/1999 Bill Concurred as Amended -- VOTE: 7 - 0
 FINAL DISPOSITION 04/20/1999 Chapter Number Assigned
-
- HB 47** **SPONSOR:** Anderson, Shiell **SHORT TITLE:** Uniform statute of limitations for insurance actions
 BY REQUEST OF: State Auditor
 REFERRED ON: 01/28/1999 **HEARD ON:** 03/11/1999
 EXECUTIVE ACTION: 03/18/1999 Bill Concurred as Amended -- VOTE: 7 - 0
 FINAL DISPOSITION 04/20/1999 Chapter Number Assigned
-
- HB 63** **SPONSOR:** Simon, Bruce **SHORT TITLE:** Require the department of commerce to adopt the most recent building codes
 REFERRED ON: 01/27/1999 **HEARD ON:** 03/03/1999
 REFERRED ON: 03/10/1999
 EXECUTIVE ACTION: 03/09/1999 Bill Concurred as Amended -- VOTE: 4 - 2
 TABLED ON: 03/17/1999
 FINAL DISPOSITION 04/22/1999 (S) Died in Standing Committee
-
- HB 73** **SPONSOR:** Rose, Sam **SHORT TITLE:** Revise license procedures for certain businesses/transfer functions to revenue
 BY REQUEST OF: Department Of Revenue
 REFERRED ON: 01/27/1999 **HEARD ON:** 03/02/1999
 EXECUTIVE ACTION: 03/02/1999 Bill Concurred -- VOTE: 5 - 0
 FINAL DISPOSITION 03/16/1999 Chapter Number Assigned
-
- HB 100** **SPONSOR:** Simon, Bruce **SHORT TITLE:** Generally revise laws administered by the state auditor
 BY REQUEST OF: State Auditor
 REFERRED ON: 02/23/1999 **HEARD ON:** 03/09/1999
 EXECUTIVE ACTION: 03/13/1999 Bill Concurred as Amended -- VOTE: 4 - 0
 FINAL DISPOSITION 04/29/1999 Chapter Number Assigned
-

122

MINUTES

**MONTANA SENATE
56th LEGISLATURE - REGULAR SESSION
COMMITTEE ON BUSINESS AND INDUSTRY**

Call to Order: By CHAIRMAN JOHN HERTEL, on March 9, 1999 at 9:00
A.M., in Room 410 Capitol.

ROLL CALL

Members Present:

Sen. John Hertel, Chairman (R)
Sen. Mike Sprague, Vice Chairman (R)
Sen. Dale Berry (R)
Sen. Vicki Cocchiarella (D)
Sen. Bea McCarthy (D)
Sen. Glenn Roush (D)
Sen. Fred Thomas (R)

Members Excused: None.

Members Absent: None.

Staff Present: Bart Campbell, Legislative Branch
Mary Gay Wells, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 100, 3/6/1999
HB 282, 3/6/1999
HB 512, 3/6/1999
Executive Action: HB 282; HB 512

{Tape : 1; Side : A; Approx. Time Counter : 0}

HEARING ON HB 100

Sponsor: REP. BRUCE SIMON, HD 18, BILLINGS

Proponents: Frank Cote, Deputy Insurance Commissioner
Steve Turkewicz, MT Auto Dealers Assoc.
David Dennis, D. A. Davidson, Securities Industry
Assoc.
Mona Jamison, General Motors Corp.
Mary Allen, MT Medical Benefits Plan

Opponents: None

Opening Statement by Sponsor:

REP. BRUCE SIMON, HD 18, BILLINGS. This will be a very short bill. This is truly a housekeeping bill from the State Auditor's Office. There are changes that need to be made in statute because of changes in the federal laws, etc. The process that the Department goes through is putting together a proposal. This is then shared with all those in the industry and legal departments around the country. If anyone has a problem with the proposed changes, it gets pulled out of the bill. There is nothing in the bill that would be controversial. The next purpose of the bill concerns an accreditation standard that has to be met. By being accredited, the Department is able to examine Montana domiciled companies. Their examinations would be accepted across the nation. So if our Montana companies want to do business out of the state, they don't have to pay a separate examining fee in every state in which they would like to do business. This is important to Montana domiciled insurance companies. So periodically, it is necessary to go through our statutes and clean them up.

Proponents' Testimony:

Frank Cote, Deputy Insurance Commissioner. I would like to announce that our Department has been accredited for another five years. I would like to address the amendments **EXHIBIT(1)**. The amendments do two things. They correct a mistake that was done by the Legislative Services Division when they put an amendment in the House. The second thing is they correct a mistake that I made when I put an amendment together for the House. The bill is

a bit different in that in past years we only included insurance code changes. This year we included the housekeeping measures of the securities department as well.

Steve Turkewicz, MT Auto Dealers Assoc. Our members are involved in credit insurance and a couple other products governed by the insurance commissioner. We appreciate this bill and ask for your support.

David Dennis, D. A. Davidson, Securities Industry Assoc. I have had my staff review the bill and I can testify that it is a housekeeping bill and does clarify some important sections of the advisory provisions of the securities laws. We urge your favorable consideration.

Mona Jamison, General Motors Corp. We support this bill, in particular Section 66 pertaining to service contracts. Thank you.

Mary Allen, MT Medical Benefits Plan. We support this bill with the amendments. Thank you.

{Tape : 1; Side : A; Approx. Time Counter : 5.4}

Opponents' Testimony: None

Questions from Committee Members and Responses:

SEN. MIKE SPRAGUE asked **Frank Cote** about the National Automobile Dealers Assoc. (NADA) Official Used Car Guide and would it will be used for appraisal purposes for replacement value. When the NADA book is used for replacement value, is the wholesale loan value considered. **Mr. Cote** replied that particular amendment came about in the House. In 1995 Legislative Session, Senator Holden proposed a bill that allowed adjustors to use Blue Book value when determining a total vehicle loss. If the consumer agreed to the Blue Book value, they can use essentially whatever they want, wholesale or whatever. If the consumer doesn't agree, then a market exam has to be conducted to see what that vehicle is worth. Unfortunately, when Senator Holden's bill was passed, he had referenced a section of code entitled 61 and in the same session, Section 61 was repealed. The bill said you can use the Blue Book value as is stated in Section 61, but there was no

title 61 section. That was brought to our attention after the bill had been introduced an amendment to put in the Blue Book so what Senator Holden wanted accomplished could be accomplished. In essence, the consumer and insurance company would have to agree on the Blue Book value. If not, a market survey would have to be done. If an automobile is of vintage age, the consumer would have to work with the adjuster to assess the value. This amendment will in no way affect the relationship of consumer and adjuster other than to make it easier for some consumers to get a check right away if they agree with the insurance company and the Blue Book value that they are offering. Senator Holden wanted the adjuster to be able to negotiate with the consumer. If they agree, the adjuster could write them a check right then and there. Under previous law, the insurance company and the adjuster were required to get a market survey valuation before they could make an offer to the customer. It could take a couple of weeks for the consumer to get paid. Therefore the process could be simplified.

{Tape : 1; Side : A; Approx. Time Counter : 10.1}

Closing by Sponsor:

REP. SIMON closed. I will be brief. This bill laid on the table in the House Business & Labor Committee until the mid-term break for the reason that I wanted all the interested parties to have an opportunity to give their input into the bill. I would appreciate a Do Concur.

{Tape : 1; Side : A; Approx. Time Counter : 11.1}

HEARING ON HB 512

Sponsor: REP. LOREN SOFT, HD 12, BILLINGS

Proponents: Joan Cassidy, MT Addiction Service Providers
Rod Robinson, MASP
Roger Curtis, MASP
Candace Payne, Rimrock Foundation
Sami Butler, MT Nurses Assoc.
Claudia Clifford, Health Policy Specialist,
Insurance Department, State Auditor
Susan Witte, Blue Cross/Blue Shield

DATE 3-9-99

17.

HB 100 Amendments to Second Reading
By request of the State Auditor's Office
March 9, 1999

1. Page 18, line 21.
Following: "or"
Strike: "clients"
2. Page 19, line 7.
Following: "or"
Strike: "clients"
3. Page 105, lines 5 and 7.
Following: "through"
Strike: "~~69~~ 72"
Insert: "70"
4. Page 105, line 20.
Following: "31,"
Strike: "35,"
5. Page 105, line 22.
Following: "SECTION"
Strike: "36"
Insert: "35"

DATE March 9, 1999

SENATE COMMITTEE ON Bus. & Ind

BILLS BEING HEARD TODAY: HB 100; HB 512; HB 282

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
CANDACE Payne	442-7450	Rimrock Foundation	AB 512	✓	
Samus Butler	Helena	MAIA	512	✓	
Claudia Clifford	Helena	State Auditor's Office	512	✓	
Tom Bovington	227-6792	Concentric Systems	282	✓	
Brad Githen	855-5539	MT Retail Assoc	100	✓	
Frank Rite	443-7700	ST. Audits	100	✓	
MARY ALLEN	443-7531	MMBP	100	✓	
Jacqueline Denmark	442-0230	Am. Ins. Assn	100	✓	
Doug Van Storsen/jr	"	State Farm	100	✓	
John Mitropoulos/jr		Farmers	100	✓	
Sue Kringsartner/jr		Alliance	100	✓	
Mark Baker/jr		NAII	100	✓	
David Dennis	791-7333	P.A. Davidson Securities Industry Assoc.	100	✓	

Susan C. Witt

Tom Ebzery

VISITOR REGISTER

Bluecross BlueShield
Yellowstone Comm Health Plan

512 ✓

512 ✓

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE March 9, 1999

SENATE COMMITTEE ON Business & Industry

BILLS BEING HEARD TODAY: HB 100, HB 512, HB 282

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Penny Mc Eroy	497-2587	MT. Power	5282	X	
MARK CADWALLADER	444-0280	MT. Dept & Labor	HB 282		
Rich Hutchinson	761-4102	Hutchinson Electric	HB 282		
KEN SWITZER	588-8585	MARTEL CONST.	HB 282	X	
Jean Cassidy	723-4001	MT Addiction Serv. Prov	HB 512	X	
ROGER CURTISS	586-5443	MT Addiction Service Prop.	HB 512	X	
Gloria Paladichuk	443-0226	Richland Economic City of Glendora	HB 282	X	
Steve Turkiewicz	442-1233	MT Auto Dealers Assn	HB 100	X	
MUNA Jamison	442-5581	MT Addiction Serv. Prov	HB 512	X	
MUNA Jamison	442-5581	GM	HB 100	X	
Jim Nys	443-7169	S. H. Rem	HB 282	X	
John Flink	442-1944	MHA	HB 512	X	
Rod Robinson	727-2512	MTASP	HB 512	X	

LANCAMELTON 442-2180 MSBA
VISITOR REGISTER

HB 282 X

INFO ONLY

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE March 9, 1999

SENATE COMMITTEE ON Bus. & Ind.

BILLS BEING HEARD TODAY: HB 100; HB 512; HB 282

PLEASE PRINT

NAME	PHONE	REPRESENTING	BILL #	SUPPORT	OPPOSE
Ed Graham	354 3444	MMBP	512		X
Roland D Pratt	443 6188	MT Agents Service	100	X	
Joyce M. Barnes	443-6780	MAXIMUS	282	X	
Wendy Keating	444 2648	Dept Labor Job Service	282	X	
Pat Haffey	4-3299	Dept of Labor Industry	282	X	
Jerry Reck	444-1555	Dept. of Labor & Industry	282	X	
Phil Campbell		MEA-MFT	282	X	
Patrick M. Montblom	873-2845	NMOGA	282	X	
Kathleen Fleury	406 338-7777	Blackfeet Tribal Gov't	282	X	
S Mohr	444 1880	MTJTP	282		

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

LEGISLATIVE TAPE LOG

COMMITTEE:

Sen. Bus. & Ind

DATE:

3-9-99

MINUTES

CONTENT NOTES

Page 1
File A

0.0

HB
100
==

Rep. Bruce Simon, HD 18, Billings

2.6

Prop.
2

Frank Cote, Dep. Insurance Comm.,
amendments

3.8

Steve Turkewicz, MT Auto Dealers

4.2

David Dennison, DAO

4.6

Mona Jamison, GMC

5.0

Mary Allen, MT Med. Benefit
Plan

5.2

Opps. - None

5.4

Q & A. Q & A Sen. Sprague - Cote
NADA Book " "
listen & paraphrase " "

10.1

Close Rep. Simon --

11.1

HB
512
==

Rep. Loren Soft, HD 12, Billings

15.0

Prop
=

Jean Cassidy, MT. Service
addition
Providers

MINUTES

**MONTANA SENATE
56th LEGISLATURE - REGULAR SESSION
COMMITTEE ON BUSINESS AND INDUSTRY**

Call to Order: By **CHAIRMAN JOHN HERTEL**, on March 12, 1999 at 9:00 A.M., in Room 410 Capitol.

ROLL CALL

Members Present:

Sen. John Hertel, Chairman (R)
Sen. Mike Sprague, Vice Chairman (R)
Sen. Vicki Cocchiarella (D)
Sen. Bea McCarthy (D)
Sen. Glenn Roush (D)

Members Excused: Sen. Dale Berry (R)
Sen. Fred Thomas (R)

Members Absent: None.

Staff Present: Bart Campbell, Legislative Branch
Mary Gay Wells, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 598, 3/4/1999
HB 196, 3/4/1999
HB 306, 3/4/1999
Executive Action: HB 100

{Tape : 1; Side : A; Approx. Time Counter : 0}

HEARING ON HB 598

Sponsor: REP. JOE QUILICI, HD 36, BUTTE

Closing by Sponsor:

REP. ANDERSON closed. Thank you for a good hearing.

{Tape : 1; Side : B; Approx. Time Counter : 7.1}

EXECUTIVE ACTION ON HB 100

Motion: SEN. MCCARTHY moved that HB 100 BE CONCURRED IN.

Discussion: Motion: SEN. MCCARTHY moved that HB 100 BE AMENDED EXHIBIT(bus56a06).

Discussion: Bart Campbell explained the amendments. These are just clarifications. Number 1 and 2 are the only ones with substance. If you don't take "clients" out, it is unclear with the pronoun "who". Section numbers had to be changed with changes that have been made.

Vote: Motion that HB 100 BE AMENDED carried unanimously. 4-0

Motion/Vote: SEN. HERTEL moved that HB 100 BE CONCURRED IN AS AMENDED. Motion carried unanimously. 4-0



SENATE STANDING COMMITTEE REPORT

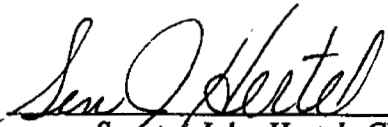
March 12, 1999

Page 1 of 1

Mr. President:

We, your committee on **Business and Industry** report that **House Bill 100** (third reading copy – blue) be concurred in as amended.

Signed:


Senator John Hertel, Chair

To be carried by Senator Bea McCarthy

And, that such amendments read:

1. Page 18, line 21.

Strike: "CLIENTS"

2. Page 19, line 7.

Strike: "CLIENTS"

3. Page 105, lines 5 and 7.

Strike: "72"

Insert: "70"

4. Page 105, line 22.

Strike: "36"

Insert: "35"

- END -

Committee Vote:

Yes 4, No 0.



561631SC.srf

DATE 3-12-99

[illegible]

Amendments to House Bill No. 100
Third Reading Copy

For the Business and Industry Committee

Prepared by Bartley Campbell
March 12, 1999 (8:52AM)

1. Page 18, line 21.

Strike: "CLIENTS"

2. Page 19, line 7.

Strike: "CLIENTS"

3. Page 105, lines 5 and 7.

Strike: "72"**Insert:** "70"

4. Page 105, line 20.

Strike: "35,"

5. Page 105, line 22.

Strike: "36"**Insert:** "35"

- END -

LEGISLATIVE TAPE LOG

COMMITTEE:

Sen. Bus. & Ind

DATE:

3-12-99

MINUTES

CONTENT NOTES

44.3

L.T. Hedberg,

44.5

Barbara Rand, N.S. West
finished in Silec B

Page 1
Side B

0.0

Opps - None

0.2

Info
Test.

Bill Squires, M^T ^{telecommunications} Assoc.

1.8

Q & A

- Sen. Cochran - Anderson -
Mike Strand

2.9

Sen. Hestel - Squires

4.5

Sen. Cochran - Anderson

" - Strand

6.2

Close Rep Anderson -

Carry:

Ex Act

7.1

HB

100

Sen. McC - BCI

amend

"

exh

6

Dis. -- Bart

McCarthy - Bart

Vote amend

4-0

McCarthy

BCIAA

4-0

Adjourn: 10:10

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 56th LEGISLATURE - REGULAR SESSION

FREE CONFERENCE - HB 100

Call to Order: By Senator Berry, on April 13, 1999 at 9:00 A.M.,
in Room 317 Capitol.

ROLL CALL

Members Present: Senator Berry
Senator Sprague
Senator Cocchiarella
Representative Simon
Representative Taylor

Members Excused: None.

Members Absent: Representative Ewer

Staff Present: Stephen Maly, Legislative Branch
Pati Jo O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: HB 100, 4/12/1999
Executive Action: None

HEARING ON HB 100

Senator Berry opened free conference committee hearing on HB 100.
{Tape : 1; Side : A; Approx. Time Counter : 0 - 20}

Motion/Vote: Rep. Simon moved that HB 100 BE AMENDED. Motion
carried unanimously. EXHIBIT(1)
{Tape : 1; Side : A; Approx. Time Counter : 20 - 30}

Frank Cote, Deputy Insurance Commissioner, State Auditor's
Office, explained need for amendments.
{Tape : 1; Side : A; Approx. Time Counter : 30 - 58}

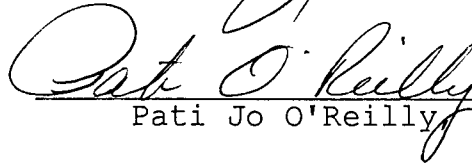
Senator Berry closed the hearing on HB 100.

ADJOURNMENT

Adjournment: 9:30 A.M.



Senator Dale Berry, Chairman



Pati Jo O'Reilly, Secretary



FREE CONFERENCE COMMITTEE

on Senate amendments to House Bill 100

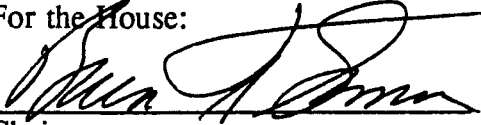
Report No. 1, April 13, 1999

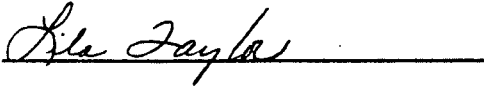
Page 1 of 2

Mr. Speaker and Mr. President:

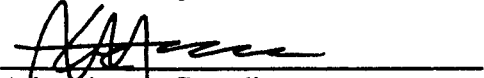
We, your ^{Free} Conference Committee met and considered Senate amendments to House Bill 100 (reference copy -- salmon) and recommend this Conference Committee report be adopted.

For the House:


Chair







Amendment Coordinator



Chief Clerk of the House

For the Senate:


Chair



And, recommend that House Bill 100 (reference copy -- salmon) be amended as follows:

1. Title, line 16.

Strike: "33-22-703,"

2. Title, line 17.

Strike: "33-22-1819,"

3. Page 63, line 25 through page 66, line 15.

ADOPT

REJECT

FCCR #1
AC HB 100-1 HB100

800842CC.ham

Strike: section 47 in its entirety
Renumber: subsequent sections

4. Page 80, line 6 through page 85, line 15.
Strike: section 54 in its entirety
Renumber: subsequent sections

5. Page 105, line 5..
Strike: "66"
Insert: "64"
Strike: "70"
Insert: "68"

6. Page 105, line 7.
Strike: "66"
Insert: "64"
Strike: "70"
Insert: "68"

7. Page 105, line 20.
Strike: "68"
Insert: "66"
Strike: "72"
Insert: "70"
Strike: "74"
Insert: "72"

- END -



AN ACT GENERALLY REVISING LAWS ADMINISTERED BY THE STATE AUDITOR; GENERALLY REVISING STATE SECURITY LAWS; GENERALLY REVISING STATE INSURANCE LAWS; DEFINING "INVOLUNTARY UNEMPLOYMENT INSURANCE"; DEFINING "GAP INSURANCE" AND "GAP AMOUNT"; DEFINING "SERVICE CONTRACT INSURANCE"; DEFINING "MECHANICAL BREAKDOWN INSURANCE"; DEFINING "PREPAID LEGAL PLAN"; PROVIDING FOR EXCLUSIONS FROM THE DEFINITION OF "PREPAID LEGAL PLAN"; AMENDING SECTIONS 27-1-306, 30-10-103, 30-10-104, 30-10-105, 30-10-107, 30-10-115, 30-10-201, 30-10-210, 31-1-233, 33-1-311, 33-1-411, 33-2-109, 33-2-502, 33-2-521, 33-2-701, 33-2-806, 33-3-202, 33-3-307, 33-4-101, 33-4-203, 33-4-311, 33-4-313, 33-5-402, 33-10-102, 33-15-336, 33-15-1107, 33-16-102, 33-16-104, 33-16-1021, 33-16-1022, 33-16-1026, 33-17-212, 33-17-236, 33-17-505, 33-17-507, 33-17-1203, 33-18-301, 33-18-1006, 33-20-121, 33-20-1201, 33-22-101, 33-22-111, 33-22-140, 33-22-307, 33-22-514, 33-22-523, 33-22-524, 33-22-1803, 33-22-1809, 33-22-1811, 33-22-1813, 33-22-1815, 33-22-1816, 33-23-212, 33-30-107, 33-30-201, 33-31-111, 33-31-202, 33-31-211, 33-31-216, 33-31-301, 33-31-401, 39-8-207, AND 61-12-303, MCA; REPEALING SECTIONS 33-2-1311, 33-7-526, 33-22-801, 33-22-802, 33-22-803, 33-22-804, 33-22-805, 33-22-806, 33-22-811, 33-22-812, 33-22-813, 33-22-814, 33-22-815, AND 33-22-816, MCA; AND PROVIDING EFFECTIVE DATES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 27-1-306, MCA, is amended to read:

"27-1-306. When replacement value to be allowed. The measure of damages in a case in which the cost of repairing a motor vehicle exceeds its value is the actual replacement value of the motor vehicle rather than its "book" value unless, after the damages arise, the parties agree to use the "book" value. "Book" value must be determined by referring to the used car guides listed in 61-3-503(1)(c) the most recent volume of the Mountain States Edition of the National Automobile Dealers Association (N.A.D.A.) Official Used Car Guide, the National Edition of the N.A.D.A. Appraisal Guides Official Older Used Car

Guide, or another nationally published used vehicle or appraisal guide approved by the department of revenue. Actual replacement value is the actual cash value of the motor vehicle immediately prior to the damage. "Book" value may be used to assist in determining the actual replacement value of the motor vehicle."

Section 2. Section 30-10-103, MCA, is amended to read:

"30-10-103. Definitions. When used in parts 1 through 3 of this chapter, unless the context requires otherwise, the following definitions apply:

(1) (a) "Broker-dealer" means any person engaged in the business of effecting transactions in securities for the account of others or for the person's own account.

(b) The term does not include:

- (i) a salesperson, issuer, bank, savings institution, trust company, or insurance company; or
- (ii) a person who does not have a place of business in this state if the person effects transactions in this state exclusively with or through the issuers of the securities involved in the transactions, other broker-dealers, or banks, savings institutions, trust companies, insurance companies, investment companies as defined in the Investment Company Act of 1940, pension or profit-sharing trusts, or other financial institutions or institutional buyers, whether acting for themselves or as trustee.

(2) "Commissioner" means the securities commissioner of this state.

(3) (a) "Commodity" means:

- (i) any agricultural, grain, or livestock product or byproduct;
- (ii) any metal or mineral, including a precious metal, or any gem or gem stone, whether characterized as precious, semiprecious, or otherwise;
- (iii) any fuel, whether liquid, gaseous, or otherwise;
- (iv) foreign currency; and
- (v) all other goods, articles, products, or items of any kind.

(b) Commodity does not include:

- (i) a numismatic coin with a fair market value at least 15% higher than the value of the metal it contains;
- (ii) real property or any timber, agricultural, or livestock product grown or raised on real property

and offered and sold by the owner or lessee of the real property; or

(iii) any work of art offered or sold by an art dealer at public auction or offered or sold through a private sale by the owner.

(4) "Commodity Exchange Act" means the federal statute of that name.

(5) "Commodity futures trading commission" means the independent regulatory agency established by congress to administer the Commodity Exchange Act.

(6) (a) "Commodity investment contract" means any account, agreement, or contract for the purchase or sale, primarily for speculation or investment purposes and not for use or consumption by the offeree or purchaser, of one or more commodities, whether for immediate or subsequent delivery or whether delivery is intended by the parties and whether characterized as a cash contract, deferred shipment or deferred delivery contract, forward contract, futures contract, installment or margin contract, leverage contract, or otherwise. Any commodity investment contract offered or sold, in the absence of evidence to the contrary, is presumed to be offered or sold for speculation or investment purposes.

(b) A commodity investment contract does not include a contract or agreement that requires, and under which the purchaser receives, within 28 calendar days after the payment in good funds of any portion of the purchase price, physical delivery of the total amount of each commodity to be purchased under the contract or agreement. The purchaser is not considered to have received physical delivery of the total amount of each commodity to be purchased under the contract or agreement when the commodity or commodities are held as collateral for a loan or are subject to a lien of any person when the loan or lien arises in connection with the purchase of each commodity or commodities.

(7) (a) "Commodity option" means any account, agreement, or contract giving a party to the account, agreement, or contract the right but not the obligation to purchase or sell one or more commodities or one or more commodity contracts, whether characterized as an option, privilege, indemnity, bid, offer, put, call, advance guaranty, decline guaranty, or otherwise.

(b) The term does not include an option traded on a national securities exchange registered with the U.S. securities and exchange commission.

(8) (a) "Federal covered adviser" means a person who ~~is~~ is

~~(a)~~ registered under section 203 of the Investment Advisers Act of 1940, ~~or~~ or

(b) ~~excluded from the definition of "investment adviser" under section 202(a)(11) of the~~

~~Investment Advisers Act of 1940~~ The term does not include a person who would be exempt from the definition of investment adviser pursuant to subsection (11)(c)(i), (11)(c)(ii), (11)(c)(iii), (11)(c)(iv), (11)(c)(v), (11)(c)(vi), (11)(c)(vii), or (11)(c)(ix).

(9) "Federal covered security" means a security that is a covered security under section 18(b) of the Securities Act of 1933 or rules promulgated by the commissioner.

(10) "Guaranteed" means guaranteed as to payment of principal, interest, or dividends.

(11) (a) "Investment adviser" means a person who, for compensation, engages in the business of advising others, either directly or through publications or writings, as to the value of securities or as to the advisability of investing in, purchasing, or selling securities or who, for compensation and as a part of a regular business, issues or promulgates analyses or reports concerning securities.

(b) The term includes a financial planner or other person who:

(i) as an integral component of other financially related services, provides the investment advisory services described in subsection (11)(a) to others for compensation, as part of a business; or

(ii) represents to any person that the financial planner or other person provides the investment advisory services described in subsection (11)(a) to others for compensation.

(c) Investment adviser does not include:

(i) an investment adviser representative;

(ii) a bank, savings institution, trust company, or insurance company;

(iii) a lawyer or accountant whose performance of these services is solely incidental to the practice of the person's profession or who does not accept or receive, directly or indirectly, any commission, payment, referral, or other remuneration as a result of the purchase or sale of securities by a client, does not recommend the purchase or sale of specific securities, and does not have custody of client funds or securities for investment purposes;

(iv) a registered broker-dealer whose performance of services described in subsection (11)(a) is solely incidental to the conduct of business and for which the broker-dealer does not receive special compensation;

(v) a publisher of any newspaper, news column, newsletter, news magazine, or business or financial publication or service, whether communicated in hard copy form or by electronic means or otherwise, that does not consist of the rendering of advice on the basis of the specific investment

situation of each client;

(vi) a person whose advice, analyses, or reports relate only to securities exempted by 30-10-104(1);

(vii) an engineer or teacher whose performance of the services described in subsection (11)(a) is solely incidental to the practice of the person's profession;

(viii) a federal covered adviser; or

(ix) other persons not within the intent of this subsection (11) as the commissioner may by rule or order designate.

(12) (a) "Investment adviser representative" means:

(i) any partner of, officer of, director of, or a person occupying a similar status or performing similar functions, or other individual, except clerical or ministerial personnel, employed by or associated with an investment adviser who:

~~(i)(A)~~ makes any recommendation or otherwise renders advice regarding securities to clients;

~~(ii)(B)~~ manages accounts or portfolios of clients;

~~(iii)(C)~~ solicits, offers, or negotiates for the sale or sells investment advisory services; or

~~(iv)(D)~~ supervises employees who perform any of the foregoing; and

(ii) with respect to a federal covered adviser, any person who is an investment adviser representative with a place of business in this state as those terms are defined by the securities and exchange commission under the Investment Advisers Act of 1940.

(b) ~~Investment adviser representative~~ The term does not include a salesperson registered pursuant to 30-10-201(1) whose performance of the services described in subsection (12)(a) is solely incidental to the conduct of business as a salesperson and for which the salesperson does not receive special compensation other than fees relating to the solicitation or offering of investment advisory services of a registered investment adviser or of a federal covered adviser who has made a notice filing under parts 1 through 3 of this chapter.

(13) "Issuer" means any person who issues or proposes to issue any security, except that with respect to certificates of deposit, voting-trust certificates, or collateral-trust certificates or with respect to certificates of interest or shares in an unincorporated investment trust not having a board of directors, or persons performing similar functions, or of the fixed, restricted management, or unit type, the term

"issuer" means the person or persons performing the acts and assuming the duties of depositor or manager pursuant to the provisions of the trust or other agreement or instrument under which the security is issued.

(14) "Nonissuer" means not directly or indirectly for the benefit of the issuer.

(15) "Offer" or "offer to sell" includes each attempt or offer to dispose of or solicitation of an offer to buy a security or interest in a security for value.

(16) "Person", for the purpose of parts 1 through 3 of this chapter, means an individual, a corporation, a partnership, an association, a joint-stock company, a trust in which the interests of the beneficiaries are evidenced by a security, an unincorporated organization, a government, or a political subdivision of a government.

(17) "Precious metal" means the following, in coin, bullion, or other form:

- (a) silver;
- (b) gold;
- (c) platinum;
- (d) palladium;
- (e) copper; and
- (f) other items as the commissioner may by rule or order specify.

(18) "Registered broker-dealer" means a broker-dealer registered pursuant to 30-10-201.

(19) "Sale" or "sell" includes each contract of sale of, contract to sell, or disposition of a security or interest in a security for value.

(20) "Salesperson" means an individual other than a broker-dealer who represents a broker-dealer or issuer in effecting or attempting to effect sales of securities. A partner, officer, or director of a broker-dealer or issuer is a salesperson only if the person otherwise comes within this definition. Salesperson does not include an individual who represents:

- (a) an issuer in:
 - (i) effecting a transaction in a security exempted by 30-10-104(1), (2), (3), (8), (9), (10), or (11);
 - (ii) effecting transactions exempted by 30-10-105, except when registration as a salesperson, pursuant to 30-10-201, is required by 30-10-105 or by any rule promulgated under 30-10-105;
 - (iii) effecting transactions in a federal covered security described in section 18(b)(4)(D) of the

Securities Act of 1933 for a qualified purchaser as defined in section 18(b)(3) of the Securities Act of 1933; or

(iv) effecting transactions with existing employees, partners, or directors of the issuer if no commission or other remuneration is paid or given directly or indirectly for soliciting any person in this state; or

(b) a broker-dealer in effecting in this state solely those transactions described in section 15(h)(2) of the Securities Exchange Act of 1934.

(21) "Securities Act of 1933", "Securities Exchange Act of 1934", "Public Utility Holding Company Act of 1935", "Investment Advisors Act of 1940", and "Investment Company Act of 1940" mean the federal statutes of those names.

(22) (a) "Security" means any note; stock; treasury stock; bond; commodity investment contract; commodity option; debenture; evidence of indebtedness; certificate of interest or participation in any profit-sharing agreement; collateral-trust certificate; preorganization certificate or subscription; transferable shares; investment contract; voting-trust certificate; certificate of deposit for a security; certificate of interest or participation in an oil, gas, or mining title or lease or in payments out of production under a title or lease; or, in general, any interest or instrument commonly known as a security, any put, call, straddle, option, or privilege on any security, certificate of deposit, or group or index of securities, including any interest in a security or based on the value of a security, or any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the foregoing.

(b) Security does not include an insurance or endowment policy or annuity contract under which an insurance company promises to pay a fixed sum of money either in a lump sum or periodically for life or some other specified period.

(23) "State" means any state, territory, or possession of the United States, as well as the District of Columbia and Puerto Rico.

(24) "Transact", "transact business", or "transaction" includes the meanings of the terms "sale", "sell", and "offer".

Section 3. Section 30-10-104, MCA, is amended to read:

"30-10-104. **Exempt securities.** Sections 30-10-202 through 30-10-207 and 30-10-211 do not apply to any of the following securities:

(1) any security, including a revenue obligation, issued or guaranteed by the United States, any state, any political subdivision of a state, or any agency or corporate or other instrumentality of one or more of the foregoing; provided, however, 30-10-202 through 30-10-207 and 30-10-211 apply to a security issued by any of the foregoing that is payable solely from payments to be received in respect of property or money used under a lease, sale, or loan arrangement by or for a nongovernmental industrial or commercial enterprise, unless the enterprise or any security of which it is the issuer is within any of the exemptions enumerated in subsections (2) through (15) of this section;

(2) any security issued or guaranteed by Canada, a Canadian province, a political subdivision of a province, or an agency or corporate or other instrumentality of one or more of the foregoing or any other foreign government with which the United States currently maintains diplomatic relations if the security is recognized as a valid obligation by the issuer or guarantor;

(3) any security issued by and representing an interest in or a debt of or guaranteed by a bank organized under the laws of the United States or a bank, savings institution, or trust company organized and supervised under the laws of any state;

(4) any security issued by and representing an interest in, or a debt of, or guaranteed by a federal savings and loan association or a building and loan or similar association organized under the laws of any state and authorized to do business in this state;

(5) any security issued or guaranteed by a federal credit union or a credit union, industrial loan association, or similar association organized and supervised under the laws of this state;

(6) any security issued or guaranteed by a railroad, other common carrier, public utility, or holding company ~~which~~ that is:

(a) subject to the jurisdiction of the interstate commerce commission;

(b) a registered holding company under the Public Utility Holding Company Act of 1935 or a subsidiary of a registered holding company within the meaning of that act;

(c) regulated in respect of its rates and charges by a governmental authority of the United States or any state or municipality; or

(d) regulated in respect to the issuance or guarantee of the security by a governmental authority

of the United States, any state, Canada, or any Canadian province; also equipment trust certificates in respect to equipment conditionally sold or leased to a railroad or public utility if other securities issued by the railroad or public utility would be exempt under this subsection;

(7) any security that meets all of the following conditions:

(a) if the issuer is not organized under the laws of the United States or a state, it has appointed ~~a~~ duly an authorized agent in the United States for service of process and has set forth the name and address of the agent in its prospectus;

(b) a class of the issuer's securities is required to be and is registered under section 12 of the Securities Exchange Act of 1934 and has been registered for the 3 years immediately preceding the offering date;

(c) the issuer or a significant subsidiary has not had a material default during the last 7 years, or during the issuer's existence if that period is less than 7 years, in the payment of:

(i) principal, interest, dividend, or sinking fund installment on preferred stock or indebtedness for borrowed money; or

(ii) rentals under leases with terms of 3 years or more;

(d) the issuer has had consolidated net income, before extraordinary items and the cumulative effect of accounting changes, of at least \$1 million in 4 of its last 5 fiscal years, including its last fiscal year; and if the offering is of interest-bearing securities, has had for its last fiscal year such net income, but before deduction for income taxes and depreciation, of at least 1 1/2 times the issuer's annual interest expense, giving effect to the proposed offering and the intended use of the proceeds. "Last fiscal year", as used in this subsection (7)(d), means the most recent year for which audited financial statements are available, provided that the statements cover a fiscal period ended not more than 15 months from the commencement of the offering.

(e) if the offering is of stock or shares, other than preferred stock or shares, the securities have voting rights and rights including the right to have at least as many votes per share and the right to vote on at least as many general corporate decisions as each of the issuer's outstanding classes of stock or shares, except as otherwise required by law;

(f) if the offering is of stock or shares, other than preferred stock or shares, the securities are owned beneficially or of record on any date within 6 months prior to the commencement of the offering

by at least 1,200 persons and on that date there are at least 750,000 of the shares outstanding with an aggregate market value, based on the average bid price for that day, of at least \$3,750,000. In connection with the determination of the number of persons who are beneficial owners of the stock or shares of an issuer, the issuer or broker-dealer may rely in good faith for the purposes of this section upon written information furnished by the record owners.

(8) any security issued by any person organized and operated not for private profit but exclusively for religious, educational, benevolent, charitable, fraternal, social, athletic, or reformatory purposes if the issuer pays a fee of \$50 and files with the commissioner 20 days prior to the offering a written notice specifying the terms of the offer and the commissioner does not disallow the exemption in writing within the 20-day period;

(9) any commercial paper that arises out of a current transaction or the proceeds of which have been or are to be used for the current transaction and that evidences an obligation to pay cash within 9 months of the date of issuance, exclusive of days of grace, or any renewal of the paper ~~which~~ that is likewise limited or any guarantee of the paper or of any renewal, when the commercial paper is sold to banks or insurance companies;

(10) any investment contract issued in connection with an employee's stock purchase, savings, pension, profit-sharing, or similar benefit plan;

(11) any security for which the commissioner determines by order that an exemption would better serve the purposes of 30-10-102 than would registration. The fee for this exemption must be as prescribed in 30-10-209(4).

(12) any security listed or approved for listing upon notice of issuance on the New York stock exchange, the American stock exchange, the Pacific stock exchange, the Midwest stock exchange, the Chicago board of options exchange, the Philadelphia stock exchange, the Boston stock exchange, or any other stock exchange registered with the federal securities and exchange commission and approved by the commissioner; any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the foregoing. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(13) any national market system security listed or approved for listing upon notice of issuance on

the national association of securities dealers automated quotation system or any other national quotation system approved by the commissioner; any other security of the same issuer that is of senior or substantially equal rank; any security called for by subscription rights or warrants so listed or approved; or any warrant or right to purchase or subscribe to any of the securities listed in this subsection. The commissioner may by rule or order limit, restrict, or otherwise condition the terms under which any security may be exempt under this subsection.

(14) any security issued by and representing an interest in, or a debt of, or any security guaranteed by any insurer organized and authorized to transact business under the laws of any state;

(15) any security for which an offer or sale is not directed to or received by a person in this state, and the issuer does not maintain a place of business in the state."

Section 4. Section 30-10-105, MCA, is amended to read:

"**30-10-105. Exempt transactions -- rulemaking.** Except as expressly provided in this section, 30-10-201 through 30-10-207 and 30-10-211 do not apply to the following transactions:

(1) a nonissuer isolated transaction, whether effected through a broker-dealer or not. A transaction is presumed to be isolated if it is one of not more than three transactions during the prior 12-month period.

(2) (a) a nonissuer distribution of an outstanding security by a broker-dealer registered pursuant to 30-10-201 if:

(i) quotations for the securities to be offered or sold (or the securities issuable upon exercise of any warrant or right to purchase or subscribe to the securities) are reported by the automated quotations system operated by the national association of securities dealers, inc., (~~NASDAQ~~) or by any other quotation system approved by the commissioner by rule; or

(ii) the security has a fixed maturity or a fixed interest or dividend provision and there has been no default during the current fiscal year or within the 3 preceding fiscal years or if the issuer and any predecessors have been in existence for less than 3 years and there has been no default in the payment of principal, interest, or dividends on the security.

(b) The commissioner may by order deny or revoke the exemption specified in subsection (2)(a) with respect to a specific security. Upon the entry of an order, the commissioner shall promptly notify

all registered broker-dealers that it has been entered and give the reasons for the order and shall notify them that within 15 days of the receipt of a written request, the matter will be set for hearing. If a hearing is not requested and is not ordered by the commissioner, the order remains in effect until it is modified or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after notice of and opportunity for hearing to all interested persons, may modify or vacate the order or extend it until final determination. An order under this subsection may not operate retroactively. A person may not be considered to have violated parts 1 through 3 of this chapter by reason of any offer or sale effected after the entry of an order under this subsection if the person sustains the burden of proof that the person did not know and in the exercise of reasonable care could not have known of the order.

(3) a nonissuer transaction effected by or through a registered broker-dealer pursuant to an unsolicited order or offer to buy, but the commissioner may require that the customer acknowledge upon a specified form that the sale was unsolicited and that a signed copy of each form be preserved by the broker-dealer for a specified period;

(4) a transaction between the issuer or other person on whose behalf the offering is made and an underwriter or between underwriters;

(5) a transaction by an executor, administrator, sheriff, marshal, receiver, trustee in bankruptcy, guardian, or conservator in the performance of official duties;

(6) a transaction executed by a bona fide pledgee without any purpose of evading parts 1 through 3 of this chapter;

(7) an offer or sale to a bank, savings institution, trust company, insurance company, investment company as defined in the Investment Company Act of 1940, pension or profit-sharing trust, or other financial institution or institutional buyer or to a broker-dealer, whether the purchaser is acting for itself or in a fiduciary capacity;

(8) (a) a transaction pursuant to an offer made in this state directed by the offeror to not more than 10 persons (other than those designated in subsection (7)) during any period of 12 consecutive months, if:

(i) the seller reasonably believes that all the buyers are purchasing for investment; and

(ii) a commission or other remuneration is not paid or given directly or indirectly for soliciting a prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if the

securities involved are registered with the United States securities and exchange commission under the federal Securities Act of 1933, as amended;

(b) any transaction pursuant to an offer made in this state directed by the offeror to not more than 25 persons, other than those designated in subsection (7), during any period of 12 consecutive months if:

(i) the seller reasonably believes that all the buyers are purchasing for investment;

(ii) a commission or other remuneration is not paid or given directly or indirectly for soliciting ~~any~~ a prospective buyer; provided, however, that a commission may be paid to a registered broker-dealer if the securities involved are registered with the United States securities and exchange commission under the federal Securities Act of 1933, as amended; and

(iii) the offeror applies for and obtains the written approval of the commissioner prior to making any offers in this state and pays a filing fee that must accompany the application for approval. The commissioner may deny an application.

(c) For the purpose of the exemptions provided for in this subsection (8), an offer to sell is made in this state, whether or not the offeror or any of the offerees is then present in this state, if the offer either originates from this state or is directed by the offeror to this state and received at the place to which it is directed (or at any post office in this state in the case of a mailed offer).

(9) an offer or sale of a preorganization certificate or subscription if:

(a) a commission or other remuneration is not paid or given directly or indirectly for soliciting a prospective subscriber;

(b) the number of subscribers does not exceed 25; and

(c) a payment is not made by a subscriber;

(10) a transaction pursuant to an offer to existing security holders of the issuer, including persons who at the time of the transaction are holders of convertible securities, nontransferable warrants, or transferable warrants exercisable within not more than 90 days of their issuance, if:

(a) a commission or other remuneration (other than a standby commission) is not paid or given directly or indirectly for soliciting any security holder in this state; or

(b) the issuer first files a notice specifying the terms of the offer and the commissioner does not by order disallow either subsection (10)(a) or the notice specifying the terms of the offer;

(11) an offer, but not a sale, of a security for which registration statements have been filed under both parts 1 through 3 of this chapter and the Securities Act of 1933 if a stop, refusal, denial, suspension, or revocation order is not in effect and a public proceeding or examination looking toward an order is not pending under either law;

(12) an offer, but not a sale, of a security for which a registration statement has been filed under parts 1 through 3 of this chapter and the commissioner does not disallow the offer in writing within 10 days of the filing;

(13) the issuance of a ~~stock~~ security dividend, whether the corporation distributing the dividend is the issuer of the ~~stock~~ security or not, if nothing of value is given by ~~stockholders~~ security holders for the distribution other than the surrender of a right to a cash dividend when the ~~stockholder~~ security holder can elect to take a dividend in cash or ~~stock~~ in securities;

(14) a transaction incident to a right of conversion, ~~or~~ a statutory or judicially approved reclassification, or a recapitalization, reorganization, quasi-reorganization, stock split, reverse stock split, merger, consolidation, or sale of assets;

(15) a transaction in compliance with rules that the commissioner may adopt to serve the purposes of 30-10-102. The commissioner may require that 30-10-201 through 30-10-207 and 30-10-211 apply to any ~~or all~~ transactional exemptions adopted by rule.

(16) a transaction in the securities of a certified Montana capital company or a certified Montana small business investment capital company, as defined in 90-8-104, ~~provided that if~~ the company first files all disclosure documents, along with a consent to service of process, with the commissioner. The commissioner may not charge a fee for the filing.

(17) the sale of a commodity investment contract traded on a commodities exchange recognized by the commissioner at the time of sale;

(18) a transaction within the exclusive jurisdiction of the commodity futures trading commission as granted under the Commodity Exchange Act;

(19) a transaction that:

(a) involves the purchase of one or more precious metals;

(b) requires, and under which the purchaser receives within 7 calendar days after payment in good funds of any portion of the purchase price, physical delivery of the quantity of the precious metals

purchased. For the purposes of this subsection, physical delivery is considered to have occurred if, within the 7-day period, the quantity of precious metals, whether in specifically segregated or fungible bulk, purchased by the payment is delivered into the possession of a depository, other than the seller, that:

(i) (A) is a financial institution, meaning a bank, savings institution, or trust company organized under or supervised pursuant to the laws of the United States or of this state;

(B) is a depository the warehouse receipts of which are recognized for delivery purposes for any commodity on a contract market designated by the commodity futures trading commission; or

(C) is a storage facility licensed by the United States or any agency of the United States; and

(ii) issues, and the purchaser receives, a certificate, document of title, confirmation, or other instrument evidencing that the quantity of precious metals has been delivered to the depository and is being and will continue to be held on the purchaser's behalf, free and clear of all liens and encumbrances other than:

(A) liens of the purchaser;

(B) tax liens;

(C) liens agreed to by the purchaser; or

(D) liens of the depository for fees and expenses that previously have been disclosed to the purchaser.

(c) requires the quantity of precious metals purchased and delivered into the possession of a depository, as provided in subsection (19)(b), to be physically located within Montana at all times after the 7-day delivery period provided in subsection (19)(b), and the precious metals are in fact physically located within Montana at all times after that delivery period;

(20) a transaction involving a commodity investment contract solely between persons engaged in producing, processing, using commercially, or handling as merchants each commodity subject to the contract or any byproduct of the commodity;

(21) an offer or sale of a security to an employee of the issuer, pursuant to an employee stock ownership plan qualified under section 401 of the Internal Revenue Code; or

(22) (a) an offer or sale of securities by a cooperative association organized under the provisions of Title 35, chapter 15, or under the laws of another state that are substantially the same as the provisions of Title 35, chapter 15, if the offer and sale are only to members of the cooperative association

or the purchase of the securities is necessary or incidental to establishing membership in the cooperative association;

(b) a cooperative organized under the laws of another state may not take advantage of the exemption created by this subsection (22) unless, not less than 10 days before the issuance or delivery of the securities, the cooperative has furnished the commissioner with a general written description of the transaction and any other information the commissioner may require by rule or otherwise. The commissioner shall promulgate rules establishing a list of states whose laws are considered substantially the same as Title 35, chapter 15, for the purposes of this subsection (22)."

Section 5. Section 30-10-107, MCA, is amended to read:

"30-10-107. Administration. (1) The administration of the provisions of parts 1 through 3 of this chapter must be under the general supervision and control of the state auditor, the ex officio securities commissioner. The commissioner may, from time to time, make, amend, and rescind rules and forms as necessary to carry out the provisions of parts 1 through 3 of this chapter. A rule or form may not be adopted unless the commissioner finds that the action is necessary or appropriate in the public interest or for the protection of investors and consistent with the purposes of the policy and provisions of parts 1 through 3 of this chapter. In prescribing rules and forms, the commissioner may cooperate with the securities administrators of the other states and the securities and exchange commission with a view to effectuating the policy of parts 1 through 3 of this chapter to achieve maximum uniformity in the form and content of registration statements, applications, and reports ~~wherever~~ whenever practicable.

(2) It is unlawful for the commissioner or any of the commissioner's officers or employees to use for personal benefit any information filed with or obtained by the commissioner and not made public. The provisions of parts 1 through 3 of this chapter do not authorize the commissioner or any of the commissioner's officers or employees to disclose any information or the fact that any investigation is being made, except among themselves or when necessary or appropriate in a proceeding or investigation under parts 1 through 3 of this chapter.

(3) The provisions of parts 1 through 3 of this chapter imposing liability do not apply to any act done or omitted in good faith in conformity with any rule, form, or order of the commissioner, notwithstanding that the rule or form may later be amended or rescinded or be determined by judicial or

other authority to be invalid for any reason.

(4) Every hearing in an administrative proceeding must be public unless the commissioner grants a request joined in by all the respondents that the hearing be conducted privately.

(5) A document is filed when it is received by the commissioner. The commissioner shall keep a register of all applications for registration and registration statements that are or have ever been effective under parts 1 through 3 of this chapter and all denial, suspension, or revocation orders that have ever been entered under parts 1 through 3 of this chapter. The register must be open for public inspection. The information contained in or filed with any registration statement, application, or report may be made available to the public under rules the commissioner prescribes.

(6) Upon request and at a reasonable charge, the commissioner shall furnish to any person photostatic or other copies, certified if requested, of any entry in the register or any document that is a matter of public record. In any proceeding or prosecution under parts 1 through 3 of this chapter, any certified copy is prima facie evidence of the contents of the entry or document certified.

(7) To serve the purposes of 30-10-102, the commissioner may cooperate with the securities and exchange commission, the commodity futures trading commission, the securities investor protection corporation, the securities registration depository, any national securities exchange, or national securities association registered under the Securities Exchange Act of 1934, any national or international organization of securities officials or agencies, and any governmental agency, corporation, or body.

(8) Except as specifically provided in this title, an order or notice may be given to a person by personal delivery or by mail addressed to that person at the person's last recorded principal place of business on file at the commissioner's office. An order or notice that is mailed is considered to have been given at the time it is mailed."

Section 6. Section 30-10-115, MCA, is amended to read:

"**30-10-115. Deposits to the general fund.** (1) All fees, ~~examination charges~~, and miscellaneous charges received by the commissioner pursuant to parts 1 through 3 of this chapter, except for portfolio registration fees described in 30-10-209(1)(d), must be deposited in the general fund.

(2) All portfolio registration fees collected under 30-10-209(1)(d) and examination costs collected under 30-10-210 must be deposited in the state special revenue account to the credit of the state

auditor's office. The funds allocated by this section to the state special revenue account may only be used to defray the expenses of the state auditor's office in discharging its administrative and regulatory powers and duties in relation to portfolio registration and examinations. Any excess fees must be deposited in the general fund."

Section 7. Section 30-10-201, MCA, is amended to read:

"30-10-201. Registration and notice filing requirements of broker-dealers, salespersons, investment advisers, and investment adviser representatives. (1) It is unlawful for a person to transact business in this state as a broker-dealer or salesperson, except as provided in 30-10-105, unless the person is registered under parts 1 through 3 of this chapter.

(2) It is unlawful for a broker-dealer or issuer to employ a salesperson to represent the broker-dealer or issuer in this state, except in transactions exempt under 30-10-105, unless the salesperson is registered under parts 1 through 3 of this chapter.

(3) It is unlawful for ~~any~~ a person to transact business in this state as an investment adviser or as an investment adviser representative unless:

(a) the person is registered under parts 1 through 3 of this chapter;

(b) the person does not have a place of business in the state and the person's only clients in this state are:

(i) investment companies, as defined in the Investment Company Act of 1940, or insurance companies;

(ii) other investment advisers;

(iii) federal covered advisers;

(iv) broker-dealers;

(v) banks;

(vi) trust companies;

(vii) savings and loan associations;

(viii) employee benefit plans with assets of not less than \$1 million;

(ix) governmental agencies or instrumentalities, whether acting for themselves or as trustees with investment control; or

(x) other institutional investors as designated by rule or order of the commissioner; or

(c) the person does not have a place of business in this state and during the preceding 12-month period, the person has not had more than five clients who are residents of this state, other than those clients specified in subsection (3)(b).

(4) Except for federal covered advisers whose only clients are clients listed in subsection (3)(b) or who meet the requirements of subsection (3)(c), it is unlawful for a federal covered adviser to conduct advisory business in this state unless the federal covered adviser complies with the provisions of subsection (6)(b).

(5) (a) It is unlawful for a person required to be registered as an investment adviser under Title 30, chapter 10, parts 1 through 3, to employ an investment adviser representative unless the investment adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through 3.

(b) It is unlawful for a federal covered adviser to employ, supervise, or associate with an investment adviser representative who maintains a place of business in this state unless the investment adviser representative is registered or exempt from registration under Title 30, chapter 10, parts 1 through 3.

(6) (a) A broker-dealer or a salesperson, acting as an agent for an issuer or as an agent for a broker-dealer in the offer or sale of securities for an issuer, or an investment adviser or investment adviser representative may apply for registration by filing an application in the form that the commissioner prescribes and payment of the fee prescribed in 30-10-209.

(b) Except for a federal covered adviser whose only clients are those listed in subsection (3)(b) or who meet the requirements of subsection (3)(c), a federal covered adviser shall, prior to acting as a federal covered adviser in this state, pay submit a notice filing to the commissioner consisting of the fee prescribed in 30-10-209 and ~~shall file with the commissioner~~ copies of any documents filed with the securities and exchange commission that the commissioner requires by rule or order. A notice filing is effective upon its receipt by the commissioner.

(7) The application must contain whatever information the commissioner requires. A registration application of a broker-dealer, salesperson, investment adviser, or investment adviser representative may not be withdrawn before the commissioner approves or denies the registration, without the express

written consent of the commissioner.

(8) When the registration requirements are met, the commissioner shall make the registration effective. An effective registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative may not be withdrawn or terminated without the express written consent of the commissioner.

(9) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or a notice filing by a federal covered adviser:

(a) is effective until December 31 following the registration or notice filing or any other time as the commissioner may by rule adopt; and

(b) may be renewed pursuant to subsection (11).

(10) (a) The registration of a salesperson is not effective during any period when the salesperson is not associated with an issuer or a registered broker-dealer specified in the application. When a salesperson begins or terminates a connection with an issuer or registered broker-dealer, the salesperson and the issuer or broker-dealer shall promptly notify the commissioner.

(b) The registration of an investment adviser representative is not effective during any period when the person is not associated with either an investment adviser registered under this act or a federal covered adviser with an effective notice filing ~~and~~ who is specified in the application. When an investment adviser representative begins or terminates a connection with an investment adviser, the investment adviser shall promptly notify the commissioner. When an investment adviser representative begins or terminates a connection with a federal covered adviser, the investment adviser representative shall promptly notify the commissioner.

(11) Registration of a broker-dealer, salesperson, investment adviser, or investment adviser representative or notice filing for a federal covered adviser may be renewed by filing, prior to the expiration of the registration or notice filing, an application containing information as the commissioner may require to indicate any material change in the information contained in the original application or any renewal application for registration or notice filing, and payment of the fee prescribed by 30-10-209. A broker-dealer who is not a member of ~~NASD~~ the national association of securities dealers, inc., is required to file a financial statement of the broker-dealer within 90 days of the end of the broker-dealer's fiscal year, except as provided in section 15 of the Securities Exchange Act of 1934. A registered broker-dealer

or investment adviser may file an application for registration of a successor, to become effective upon approval of the commissioner.

(12) (a) Except as provided in section 15 of the Securities Exchange Act of 1934 in the case of a broker-dealer and section 222 of the Investment Advisers Act of 1940 in the case of an investment adviser, every registered broker-dealer and investment adviser shall make and keep accounts and other records, except with respect to securities exempt under 30-10-104(1), as may be prescribed by the commissioner by rule or order. All required records of an investment adviser must be preserved for the period the commissioner prescribes by rule or order. All the records of a registered broker-dealer or investment adviser are subject at any time or from time to time to reasonable periodic, special, or other examinations, within or outside this state, by representatives of the commissioner, as the commissioner considers necessary or appropriate in the public interest or for the protection of investors.

(b) The commissioner may require investment advisers who are registered or required to be registered to furnish or disseminate certain information as necessary or appropriate in the public interest or for the protection of investors and advisory clients.

(c) If information contained in any document filed with the commissioner is, or becomes, inaccurate or incomplete in any material respect, the registrant or federal covered adviser ~~must~~ shall promptly file a correcting amendment.

(13) The commissioner may by order deny, suspend, or revoke registration of any broker-dealer, salesperson, investment adviser, or investment adviser representative if the commissioner finds that the order is in the public interest and that the applicant or registrant or, in the case of a broker-dealer or investment adviser, any partner, officer, director, person occupying a similar status or performing similar functions, or person directly or indirectly controlling the broker-dealer or investment adviser:

(a) has filed an application for registration under this section that, as of its effective date or as of any date after filing in the case of an order denying effectiveness, was incomplete in any material respect or contained any statement that was, in the light of the circumstances under which it was made, false or misleading with respect to any material fact;

(b) has willfully violated or willfully failed to comply with any provision of parts 1 through 3 of this chapter or a predecessor law or any rule or order under parts 1 through 3 of this chapter or a predecessor law;

(c) has been convicted of any misdemeanor involving a security or any aspect of the securities business or any felony;

(d) is permanently or temporarily enjoined by any court of competent jurisdiction from engaging in or continuing any conduct or practice involving any aspect of the securities business;

(e) is the subject of an order of the commissioner denying, suspending, or revoking registration as a broker-dealer, salesperson, investment adviser, or investment adviser representative;

(f) is the subject of an adjudication or determination, within the past 5 years, by a securities or commodities agency or administrator of another state or a court of competent jurisdiction, that the person has violated the Securities Act of 1933, the Securities Exchange Act of 1934, the Investment Advisors Act of 1940, the Investment Company Act of 1940, or the Commodity Exchange Act or the securities or commodities law of any other state;

(g) has engaged in dishonest or unethical practices in the securities business;

(h) is insolvent, either in the sense that the person's liabilities exceed the person's assets or in the sense that the person cannot meet obligations as they mature, but the commissioner may not enter an order against a broker-dealer or investment adviser under this subsection (13) without a finding of insolvency as to the broker-dealer or investment adviser;

(i) has not complied with a condition imposed by the commissioner under this section or is not qualified on the basis of such factors as training, experience, or knowledge of the securities business;

(j) has failed to pay the proper filing fee, but the commissioner may enter only a denial order under this subsection (13), and the commissioner shall vacate any order when the deficiency has been corrected; or

(k) has failed to reasonably supervise the person's salespersons or employees or investment adviser representatives or employees to ~~assure~~ ensure their compliance with this act.

(14) The commissioner may not institute a suspension or revocation proceeding on the basis of a fact or transaction known to the commissioner when registration became effective unless the proceeding is instituted within 30 days after the date on which the registration became effective.

(15) The commissioner may by order summarily postpone or suspend registration pending final determination of any proceeding under this section.

(16) Upon the entry of the order under subsection (13), the commissioner shall promptly notify

the applicant or registrant, as well as the employer or prospective employer if the applicant or registrant is a salesperson or investment adviser representative, that it has been entered and of the reasons for the order and that if requested by the applicant or registrant within 15 days after the receipt of the commissioner's notification, the matter will be promptly set for hearing. If a hearing is not requested within 15 days and none is ordered by the commissioner, the order will remain in effect until it is modified or vacated by the commissioner. If a hearing is requested or ordered, the commissioner, after notice of and opportunity for hearing, may modify or vacate the order or extend it until final determination.

(17) If the commissioner finds that ~~any~~ a registrant or applicant for registration is no longer in existence or has ceased to do business as a broker-dealer, salesperson, investment adviser, or investment adviser representative or is subject to an adjudication of mental incompetence or to the control of a committee, conservator, or guardian or cannot be located after reasonable search, the commissioner may by order cancel the registration or application.

(18) The commissioner may, after suspending or revoking registration of any broker-dealer, salesperson, investment adviser, or investment adviser representative, impose a fine not to exceed \$5,000 upon the broker-dealer, salesperson, investment adviser, or investment adviser representative. The fine is in addition to all other penalties imposed by the laws of this state and must be collected by the commissioner in the name of the state of Montana and deposited in the general fund. Imposition of any fine under this subsection is an order from which an appeal may be taken pursuant to 30-10-308. If any broker-dealer, salesperson, investment adviser, or investment adviser representative fails to pay a fine referred to in this subsection, the amount of the fine is a lien upon all of the assets and property of the broker-dealer, salesperson, investment adviser, or investment adviser representative in this state and may be recovered by suit by the commissioner and deposited in the general fund. Failure of a broker-dealer, salesperson, investment adviser, or investment adviser representative to pay a fine also constitutes a forfeiture of the right to do business in this state under parts 1 through 3 of this chapter.

(19) A sole proprietor registered as a broker-dealer or investment adviser who does not employ other salespersons or investment adviser representatives, other than the sole proprietor, is not required to register as both a broker-dealer and a salesperson or as an investment adviser and an investment adviser representative if the sole proprietor meets the examination requirements established by the commissioner by rule.

(20) A person who is subject to the provisions of this section and who has passed the general securities principal's examination is not required to also pass the uniform investment adviser law examination. The commissioner shall by rule provide for a form that a person who passes the general securities principal's examination shall file with the commissioner as a verification of having passed the examination unless the commissioner can verify electronically that the person has passed the exam."

Section 8. Section 30-10-210, MCA, is amended to read:

"30-10-210. Examination costs. (1) An issuer, broker-dealer, or investment adviser who is examined in connection with a registration under parts 1 through 3 of this chapter shall reimburse the commissioner or any of ~~his duty~~ the commissioner's authorized agents, officers, or employees for actual travel expenses, a reasonable living expense allowance, and a per diem as compensation of examiners, ~~as which are~~ necessarily incurred on account of the examination, upon presentation of a detailed account of ~~such the~~ the charges and expenses by the commissioner or pursuant to ~~his the commissioner's~~ the commissioner's written authorization; however, ~~no~~ reimbursement of expenses may not be required for routine examinations performed in connection with an application for registration. ~~No A person may not pay and no an examiner may not~~ accept additional emolument on account of ~~such~~ an examination.

(2) The commissioner shall ~~pay to the state treasurer to the credit of the general fund all moneys received hereunder~~ deposit examination costs collected under this section in the special revenue account provided for in 30-10-115. The commissioner may give written authorization for payment of the examination costs referred to in subsection (1) by the person examined directly to the examiner.

(3) If an issuer, broker-dealer, or investment adviser fails to pay the charges and expenses referred to ~~above in subsection (1)~~, ~~the same shall~~ charges and expenses must be paid out of the funds of the commissioner in the same manner as other disbursements of ~~such those~~ those funds. The amount ~~so~~ paid is a first lien upon all of the assets and property in this state of the issuer, broker-dealer, or investment adviser and may be recovered by suit by the attorney general on behalf of the state of Montana and restored to the appropriate fund. Failure of the issuer, broker-dealer, or investment adviser to pay the charges and expenses also works a forfeiture of ~~his or its~~ the right to do business in this state under parts 1 through 3 of this chapter."

Section 9. Section 31-1-233, MCA, is amended to read:

"31-1-233. Insurance. (1) The amount, if any, included for insurance that may be purchased by the holder of the contract may not exceed the applicable premiums chargeable in accordance with the rates filed with the insurance department of this state ~~where~~ when the rates are required by law to be approved by the insurance department.

(2) All insurance purchased by the holder of the contract must be written by an insurance company authorized to do business in this state ~~and must be countersigned by a duly licensed resident insurance producer authorized to engage in the insurance business in this state.~~

(3) A buyer may be required to provide insurance on the goods at ~~his~~ the buyer's own cost for the protection of the seller or holder as well as the buyer, but the insurance is limited to insurance against substantial risk of loss, damage, or destruction of the goods.

(4) Any other insurance may be included in a retail installment transaction at the buyer's expense only if contracted for voluntarily by the buyer.

(5) If insurance for which an identified charge is made insures the life, safety, or health of the buyer or ~~his~~ the buyer's interest in the goods and is purchased by the holder, the holder shall within 30 days after the execution of the retail installment contract send or cause to be sent to the buyer a policy or policies or certificate or certificates of insurance, written by an insurance company authorized to do business in this state, clearly setting forth:

(a) the amount of the premium;

(b) the kind or kinds of insurance;

(c) the coverages; and

(d) if a policy, all the terms, exceptions, limitations, restrictions, and conditions of the contract or contracts of insurance or, if a certificate, a summary of the terms, exceptions, limitations, restrictions, and conditions.

(6) The ~~seller~~ holder may not decline existing insurance written by an insurance company authorized to do business in this state, and the buyer has the privilege of purchasing insurance from an insurance producer or broker of ~~his~~ the buyer's own selection and of selecting ~~his~~ the buyer's insurance company, ~~provided that if:~~

(a) the insurance company is acceptable to the holder, which acceptance may not be

unreasonably or arbitrarily withheld; and

(b) the inclusion of the cost of the insurance premium in the retail installment contract when the buyer selects his the buyer's insurance producer, broker, or company is optional with the ~~seller~~ holder.

(7) If any insurance is canceled or the premium adjusted, any refund of the insurance premium received by the holder must be credited to the final maturing installment of the contract except to the extent applied toward payment for a similar insurance protecting the interests of the buyer and the holder or either of them."

Section 10. Section 33-1-311, MCA, is amended to read:

"33-1-311. General powers and duties. (1) The commissioner shall enforce the applicable provisions of the laws of this state and shall execute the duties imposed on the commissioner by the laws of this state.

(2) The commissioner has the powers and authority expressly conferred upon the commissioner by or reasonably implied from the provisions of the laws of this state.

(3) The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.

(4) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as the commissioner considers proper, to determine whether any person has violated any provision of the laws of this state or to secure information useful in the lawful administration of any provision. The cost of additional examinations and investigations must be borne by the state.

(5) The commissioner shall maintain as confidential any information or document received from:

(a) the national association of insurance commissioners; or

(b) an insurance department from another state that treats the same information or document as confidential. The commissioner may provide information or documents, including information or documents that are confidential, to the national association of insurance commissioners, a state or federal law enforcement agency, or an insurance department in another state, if the recipient agrees to maintain the confidentiality of the information or documents.

~~(5)~~(6) The department is a criminal justice agency as defined in 44-5-103."

Section 11. Section 33-1-411, MCA, is amended to read:

"33-1-411. Destruction of records -- hindrance of examination -- penalty. Any A director, officer, agent, or employee of ~~any~~ a company who for the purpose of hindering any examination conducted pursuant to this part destroys any books, records, or documents required to be kept by law shall be punished by a fine of ~~not more than \$1,000~~ as provided in 33-1-317. After notice and hearing in accordance with Title 33, chapter 1, part 7, the commissioner may revoke the certificate of authority of ~~such~~ the company."

Section 12. Section 33-2-109, MCA, is amended to read:

"33-2-109. Capital or surplus funds required. (1) To qualify for authority to transact any one kind of insurance, as defined in 33-1-205 through 33-1-212, or combinations of kinds of insurance as shown below, an insurer shall possess and ~~thereafter~~ maintain unimpaired paid-in capital stock, ~~if~~ a stock insurer, or surplus, ~~if~~ a mutual or foreign reciprocal insurer, ~~in an~~ in amount not less than ~~as is~~ as applicable under the ~~schedule~~ schedules below; and shall possess when first ~~so~~ authorized ~~such~~ to transact insurance any additional funds as surplus as required under 33-2-110:

<u>(a)</u> Kind or kinds of insurance	Minimum capital or surplus required
Life	\$200,000
Disability	200,000
Life and disability	300,000
Credit life and disability	50,000
Property	400,000
Marine	400,000
Casualty	
All lines, except workers' compensation	400,000
All lines, including workers' compensation	600,000
Surety	500,000
Title	200,000

Multiple lines, ~~two or more~~ of property, marine,

casualty, or surety 800,000

(b) For insurers licensed on or after October 1, 1999:

Kind or kinds of insurance	Minimum capital or surplus required
Life	\$ 600,000
Disability	500,000
Life and disability	750,000
Credit life and disability	150,000
Property	500,000
Marine	500,000
Casualty	
All lines, except workers' compensation	500,000
All lines, including workers' compensation	750,000
Surety	500,000
Title	500,000
Multiple lines, two or more of property, marine, casualty, or surety	1,000,000

(2) ~~As to surplus required~~ Surplus requirements for qualification to transact one or more kinds of insurance ~~and thereafter to be maintained, for~~ domestic mutual insurers ~~shall be~~ are governed by Title 33, chapter 3, and surplus requirements for domestic reciprocal insurers ~~shall be~~ are governed by Title 33, chapter 5.

(3) Capital and surplus requirements ~~shall~~ must be based upon all the kinds of insurance actually transacted or to be transacted by the insurer in any ~~and all~~ areas in which it operates, whether or not only a portion of ~~such~~ the kinds are to be transacted in this state.

(4) A life insurer may also grant annuities without additional capital or additional surplus.

(5) For a credit life and disability insurer that is not a resident domestic insurer as defined in 33-1-201 and 33-1-202, the capital or surplus required by this section is an amount equal to four times the minimum capital or surplus required for credit life and disability pursuant to subsection (1)."

Section 13. Section 33-2-502, MCA, is amended to read:

"33-2-502. **Assets expressly not allowed.** In addition to assets impliedly excluded by the provisions of 33-2-501, the following expressly ~~shall~~ may not be allowed as assets in any determination of the financial condition of an insurer:

- (1) goodwill, trade names, and other like intangible assets;
- (2) advances to officers, ~~{other than policy loans}~~, whether secured or not, and advances to employees, insurance producers, and other persons on personal security only;
- (3) stock of ~~such~~ issued and owned by the insurer, owned by it, or any equity therein in the stock issued by the insurer, or loans secured thereby by stock issued by the insurer, or any proportionate interest in ~~such~~ the stock acquired or held through the ownership by ~~such~~ the insurer of an interest in another firm, corporation, or business unit;
- (4) furniture, fixtures, ~~{other than electronic data processing machines authorized under 33-2-501(11)}~~, furnishings, safes, vehicles, libraries, stationery, literature, and supplies, except:
 - (a) in the case of title insurers, ~~such~~ materials and plants ~~as~~ that the insurer is expressly authorized to invest in under 33-2-851; and
 - (b) in the case of any insurer, ~~such~~ personal property ~~as~~ that the insurer is permitted to hold pursuant to part 8 of this chapter, ~~or which that~~ is acquired through foreclosure of chattel mortgages acquired pursuant to 33-2-831, ~~or which that~~ is reasonably necessary for the maintenance and operation of real estate lawfully acquired and held by the insurer other than real estate used by it for home office, branch office, and similar purposes;
- (5) the amount, if any, by which the aggregate book value of investments as carried in the ledger assets of the insurer exceeds the aggregate value ~~thereof~~ of the investments as determined under this code title; and
- (6) prepaid expenses."

Section 14. Section 33-2-521, MCA, is amended to read:

"33-2-521. **Standard valuation of reserve liabilities law -- life insurance.** (1) The commissioner shall annually value or cause to be valued the reserve liabilities (reserves) for all outstanding life insurance

policies and annuity and pure endowment contracts of every life insurer doing business in this state and may certify the amount of any reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of reserves. In calculating the reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise.

(2) In lieu of the valuation of the reserves required in this section of any foreign or alien insurer, the commissioner may accept any valuation made or caused to be made by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section and if the official of the other state or jurisdiction accepts as sufficient and valid for all legal purposes the certificate of valuation of the commissioner when the certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

(3) Any insurer that has adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this section may, with the approval of the commissioner, adopt any lower standard of valuation but not lower than the minimum in this section. For the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required in subsection (4) may not be considered to be the adoption of a higher standard of valuation.

(4) (a) Each life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered necessary to its scope.

(b) Each life insurer, except as exempted by or pursuant to regulation, shall also annually include in the opinion required by subsection (4)(a) an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including but not limited to the investment earnings on the assets

and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts, including but not limited to the benefits under and expenses associated with the policies and contracts.

(c) The commissioner may provide by rule for a transition period for establishing any higher reserves that the qualified actuary may consider necessary in order to render the opinion required by this subsection (4).

(d) Each opinion required by this subsection (4) must be governed by the following provisions:

(i) A memorandum, in form and substance acceptable to the commissioner as specified by rule, must be prepared to support each actuarial opinion.

(ii) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or if the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the rules or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and to prepare any supporting memorandum as is required by the commissioner.

(iii) The opinion must be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1996.

(iv) The opinion must apply to all business in force, including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(v) The opinion must be based on standards adopted from time to time by the actuarial standards board and on additional standards as the commissioner may prescribe by rule.

(vi) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(vii) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(viii) Disciplinary action by the commissioner against the insurer or the qualified actuary must be

defined in rules by the commissioner.

(ix) Any memorandum in support of the opinion and any other material provided by the insurer to the commissioner in connection with those items must be kept confidential by the commissioner, may not be made public, and is not subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this subsection (4) or by rules promulgated under this subsection (4). However, the memorandum or other material may otherwise be released by the commissioner:

(A) with the written consent of the insurer; or

(B) to the American academy of actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the insurer in its marketing, is cited before any governmental agency other than a state insurance department, or is released by the insurer to the news media, all portions of the confidential memorandum are no longer confidential.

(5) For purposes of this section, "qualified actuary" means a member in good standing of the American academy of actuaries who meets the requirements set forth in the academy's rules."

Section 15. Section 33-2-701, MCA, is amended to read:

"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury. (1) Each authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner. The statement must be completed in accordance with the annual statement instructions and the accounting practices and procedures manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves. The statement must be verified by the oath of the insurer's president or ~~vice-president~~ vice president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.

The commissioner may waive the verification under oath.

(2) (a) Each domestic insurer shall file electronic ~~diskette~~ versions of its annual and quarterly financial statements with the national association of insurance commissioners. The ~~filing~~ date for submission of the annual statement ~~diskette~~ electronic filing is March 1. The ~~filing dates~~ dates for the submission of the quarterly statement diskettes electronic filings are as follows:

- (i) the first ~~calendar~~ quarter filing is due May 15;
- (ii) the second ~~calendar~~ quarter filing is due August 15; and
- (iii) the third ~~calendar~~ quarter filing is due November 15.

(b) The commissioner may exempt insurers that operate only in Montana from these filing requirements.

(3) The statement of an alien insurer must relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible. The statement must be verified by the insurer's United States manager or other authorized officer.

(4) The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or within an extension of time that the commissioner may grant.

(5) ~~Any~~ A director, officer or insurance producer, or employee of ~~any~~ a company who subscribes to, makes, or concurs in making or publishing ~~any~~ an annual statement or any other statement required by law knowing that the statement contains any material statement ~~which~~ that is false shall be punished by a fine of not more than \$1,000.

(6) At the time of filing, the insurer shall pay to the commissioner the fee for filing its statement as prescribed in 33-2-708.

(7) The commissioner may impose a fine not to exceed \$100 a day for each day after March 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed a maximum of \$1,000."

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Section 16. Section 33-2-806, MCA, is amended to read:

"33-2-806. **Diversification of investments.** An insurer shall invest in or hold as admitted assets categories of investments only within applicable limits as follows:

(1) An insurer may not, except with the consent of the commissioner, have at any one time any combination of investments in or loans upon the security of the obligations, property, or securities of any one person or insurer aggregating an amount exceeding 5% of the insurer's assets. This restriction does not apply as to general obligations of the United States of America or of any state or include policy loans made under 33-2-825.

(2) An insurer may not invest in or hold at any one time more than 10% of the outstanding voting stock of any corporation, except with the consent of the commissioner. This provision does not apply as to stock of a wholly owned subsidiary of the insurer or to controlling stock of an insurer acquired under 33-2-821.

~~(3) An insurer, other than title insurer, shall invest and maintain invested funds not less in amount than the minimum paid in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided for in 33-2-811(1), 33-2-812, and 33-2-830.~~

~~(4)~~(3) A life insurer shall also invest and keep invested its funds in an amount not less than the reserves under its life insurance policies and annuity contracts, other than variable annuities, in force in cash, in securities, in both cash and securities, or in investments provided for in 33-2-531.

~~(5)~~(4) Except with the commissioner's consent, an insurer may not have invested at any one time more than 20% of its assets in the class of securities described in 33-2-818, exclusive of obligations of public utilities.

~~(6)~~(5) Except with the commissioner's consent, an insurer may not invest and have invested at any one time in aggregate amount more than 15% of its assets in all stocks provided for in 33-2-820 and 33-2-821. Determination of the amount that an insurer has invested in common stocks for the purposes of this provision must be based on the cost of the stocks to the insurer. This provision does not apply to stock of a controlled or subsidiary insurance corporation or other corporations provided for in 33-2-821 and 33-2-822.

~~(7)~~(6) Except with the commissioner's consent, an insurer may not have invested at any one time

more than 5% of its assets in securities allowed in 33-2-824. Money market funds, as defined by the commissioner by rule, are exempt from the 5% limitation of this subsection.

~~(8)~~(7) Except with the commissioner's consent, an insurer may not have invested at any one time more than 10% of its assets in the class of securities described in 33-2-814, 33-2-819, and 33-2-823.

~~(9)~~(8) Limits of investments in real estate must be as provided in 33-2-832. Other specific limits apply as stated in the sections dealing with other respective kinds of investments."

Section 17. Section 33-3-202, MCA, is amended to read:

"**33-3-202. Articles of incorporation -- filing and approval.** (1) The incorporators of a proposed domestic insurer shall deliver the ~~quaduplicate~~ triplicate originals of the articles of incorporation to the commissioner, together with the filing fees ~~therefor~~ specified in 33-2-708. The commissioner shall examine the proposed articles of incorporation. If the commissioner finds that the articles comply with this chapter and are not in conflict with the constitution and laws of the United States or of this state, ~~he the commissioner~~ shall ~~endorse his place an endorsement of~~ approval upon each set of the articles; ~~except that. However,~~ if the commissioner finds that the proposed insurer would not be eligible for a certificate of authority under 33-2-112, ~~he the commissioner~~ shall refuse to approve the articles of incorporation and shall return them to the proposed incorporators, together with a written statement of the reasons for ~~such the~~ refusal. If approved ~~by him~~, the commissioner shall then forward the endorsed articles of incorporation, ~~with his approval endorsed thereon,~~ to the incorporators. The incorporators shall ~~forthwith~~ file one set of the articles of incorporation with the secretary of state; and one set certified by the secretary of state with the commissioner, ~~bearing the certification of the secretary of state, and one set with the county clerk of the county wherein is to be located the corporation's principal place of business; and the.~~ The remaining set of articles shall must be made a part of the corporation's record.

(2) If the commissioner finds that the proposed articles of incorporation do not comply with law, ~~he the commissioner~~ shall refuse to approve the ~~same~~ articles and shall return all sets of the proposed articles of incorporation to the proposed incorporators, together with a written statement of the reasons for ~~his the~~ refusal ~~to approve~~.

(3) The corporation ~~shall have~~ has legal existence as ~~such a corporation~~ upon the issuance of the certificate of incorporation by the secretary of state and the completion of the ~~filings~~ filing with the

commissioner referred to required in subsection (1) ~~above~~, but ~~it shall~~ the corporation may not transact business as an insurer until it has qualified for and received from the commissioner a certificate of authority as provided in this ~~code~~ title.

(4) A copy of the certificate of incorporation, ~~duly~~ certified by the secretary of state, ~~shall be~~ is admissible in all the courts of this state as prima facie evidence of ~~due~~ proper incorporation."

Section 18. Section 33-3-307, MCA, is amended to read:

"**33-3-307. Bond Bonding of officers and employees.** (1) ~~The president, secretary, and treasurer~~
When acting in a fiduciary capacity, officers and employees of each mutual insurer or stock insurer shall ~~each file with the commissioner and maintain in force so long as that individual is an officer~~ a fidelity bond ~~in an amount set by the commissioner by rule and issued by an authorized corporate surety in favor of~~
the insurer. The commissioner shall consider the insurer's exposure, total assets, and total income in determining the bond amount. In lieu of individual bonds, officers and employees may be covered under a blanket bond for the same respective amounts. The insurer shall file the blanket bond ~~must be filed~~ with the commissioner.

(2) The insurer shall pay the premium for the bond ~~must be payable by the insurer~~.

(3) A bond is not subject to cancellation except upon written notice to both the insurer and the commissioner, delivered not less than 30 days in advance of the effective date of the cancellation.

~~(4) The insurer shall provide for the bonding by authorized corporate surety of all other officers in any way responsible for the handling of the funds of the insurer.~~

~~(5)~~(4) This section may not be considered to limit the amount of bonded protection that the insurer may carry as to any officer or employee.

(5) The commissioner may adopt rules to determine the bond amount for officers and employees who are subject to the provisions of this section."

Section 19. Section 33-4-101, MCA, is amended to read:

"**33-4-101. Scope of chapter -- provisions applicable.** (1) The chapter applies to:

(a) all domestic mutual hail, fire, and other casualty insurers of farm property and stock and rural buildings formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections

40-1501 through 40-1517 of the Revised Codes of Montana, 1947;

(b) all domestic mutual rural insurers formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1601 through 40-1625 of the Revised Codes of Montana, 1947;

(c) all insurers formed under this chapter.

(2) The insurance laws of this state do not apply to or govern, either directly or indirectly, domestic farm mutual insurers except as ~~contained or referred to~~ provided in this chapter.

(3) The following chapters and sections of this title apply to farm mutual insurers to the extent applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of the express provisions of this chapter: chapter 1, parts 1 through 4, ~~and 7, 12, and 13~~; 33-2-112; 33-2-501; 33-2-502; 33-2-532 through 33-2-535; 33-2-708; ~~chapter 2, parts 13 and 16~~; 33-2-1212; ~~chapter 2, parts 13 and 16~~; 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436; and chapter 18."

Section 20. Section 33-4-203, MCA, is amended to read:

"33-4-203. Approval of articles -- commencement of corporate existence. (1) If the commissioner finds the proposed articles of incorporation to be in accordance with the provisions of this chapter and not in conflict with the constitution and laws of the United States ~~of America~~ or of this state, the commissioner shall make a certificate of the facts.

(2) If the commissioner considers the name of the proposed corporation to be so similar to one already appropriated by another company or corporation as to be likely to mislead the public, the commissioner shall reject the name applied for and shall notify the incorporators of the rejection.

(3) When the proposed articles of incorporation have been approved by the commissioner, the commissioner shall endorse the approval upon each set of the articles and forward ~~four~~ three sets of articles to the incorporators. The incorporators shall file, with the required filing fee, one of the sets of articles with the secretary of state; and one set certified by the secretary of state with the commissioner ~~bearing the certification of the secretary of state, and one set with the county clerk of the county in which the principal place of business of the corporation is located and shall pay to the secretary of state and the county clerk the customary filing fees.~~ The remaining set of articles must be made a part of the corporation's records.

(4) The corporation has legal existence upon the approval of the articles by the commissioner and completion of the filings ~~referred to~~ required in subsection (3), but it may not transact business as an insurer until it has ~~fulfilled the requirements for and has~~ obtained a certificate of authority as provided in 33-4-505."

Section 21. Section 33-4-311, MCA, is amended to read:

"33-4-311. Bonds Bonding of officers, managers, and employees. ~~(1) The treasurer and secretary of an insurer~~ When acting in a fiduciary capacity, officers, managers, and employees shall each give bonds to the insurer for the faithful performance of their duties, ~~in such amount as is designated by the board of directors.~~ Any such ~~The bond shall~~ must be one issued by an authorized corporate surety.

(2) The commissioner may adopt rules to determine the amount of the bonds required under this section."

Section 22. Section 33-4-313, MCA, is amended to read:

"33-4-313. Annual statement. The president and secretary of each insurer, on or before March 1 each year, shall prepare, affirm under oath, ~~affix the corporate seal to,~~ and file with the commissioner, on forms prescribed and furnished by the commissioner, an annual statement for the preceding calendar year showing the condition of the insurer as of December 31 of the preceding year and exhibiting the following facts:

- (1) the names of the president and secretary;
- (2) the date of the annual meeting;
- (3) the amount of insurance in force;
- (4) the number of members;
- (5) the number of assessments made during the year;
- (6) the amount paid in losses during the year;
- ~~(7) the amount of the losses claimed and not paid, with the reason for nonpayment;~~
- ~~(7)~~ (7) the number of members withdrawn, suspended, and expelled during the year;
- ~~(8)~~ (8) the number of new members admitted during the year;
- ~~(9)~~ (9) the expenses during the year;

~~{11}~~(10) the amount of money on hand;

~~{12}~~(11) the amount and character of the insurer's assets;

~~{13}~~(12) the amount of the insurer's liabilities, including any reserves required to be established under this chapter; and

~~{14}~~(13) other information concerning the insurer's affairs that the commissioner may reasonably require."

Section 23. Section 33-5-402, MCA, is amended to read:

"33-5-402. **Contributions to insurer.** The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms funds that it may require from time to time in its operations. Sums advanced may not be treated as a liability of the insurer. Except upon liquidation of the insurer, during any calendar year, the total of withdrawals and repayments of the advanced sums may not exceed the lesser of the ~~insured's~~ insurer's realized earned surplus or 10% of the sums advanced as of the previous December 31. A withdrawal or repayment may not be made without the advance approval of the commissioner. This section does not apply to bank loans or to loans for which security is given."

Section 24. Section 33-10-102, MCA, is amended to read:

"33-10-102. **Definitions.** As used in this part, the following definitions apply:

(1) "Association" means the Montana insurance guaranty association created under 33-10-103.

(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, ~~which that~~ arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if ~~such the~~ insurer becomes an insolvent insurer after July 1, 1971, and:

(i) the claimant or insured is a resident of this state at the time of the insured event; or

(ii) the property from which the claim arises is permanently located in this state.

(b) ~~"Covered claim" shall~~ Covered claim does not include any amount: ~~due a reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise.~~

(i) awarded as punitive or exemplary damages;

(ii) sought as a return of premium under a retrospective rating plan; or

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(iii) due a reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, reinsurance recoveries, contribution, or indemnification. If insolvent, a reinsurer, insurer, insurance pool, or underwriting association may not assert a claim in any amount against an insured except to the extent that the claim exceeds the policy limits of the insured's policy.

(3) "Insolvent insurer" means an insurer:

(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and

(b) determined to be insolvent by a court of competent jurisdiction.

(4) "Member insurer" means ~~any~~ a person who:

(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and

(b) is licensed to transact insurance in this state.

(5) (a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums ~~thereon on the policies~~ and dividends paid or credited to policyholders ~~on such direct business of policies to which this part applies.~~

(b) ~~"Net Net direct written premiums"~~ premiums does not include premiums on contracts between insurers or reinsurers.

(6) "Person" means any individual, corporation, partnership, association, or voluntary organization."

Section 25. Section 33-15-336, MCA, is amended to read:

"33-15-336. **Applicability.** (1) Other statutes of this state setting simplification standards for language or format do not apply to property and casualty policies.

(2) Sections 33-15-333 through 33-15-340 do not apply to policies in manuscript form or to the following kinds of insurance:

(a) ocean marine;

(b) surety and financial institution bonds;

(c) reinsurance; ~~or~~

(d) commercial aviation; or

(e) large commercial risks whose aggregate annual premiums for insurance on all risks totals at least \$100,000.

(3) A non-English policy is considered in compliance with 33-15-337 if it was translated from an English policy that complies with 33-15-337."

Section 26. Section 33-15-1107, MCA, is amended to read:

"33-15-1107. Information about grounds for nonrenewal. ~~(1) If an insured questions the facts upon which an insurer's decision to cancel or not renew is based, the insurer shall mail or deliver such information to the insured within 15 working days of receiving a written request from the insured. If the insurer or insurance producer receives a written request from an insured within 60 business days from the date on which the insurer mailed a notice of cancellation or nonrenewal to the insured, the insurer or insurance producer shall, within 21 days of receiving the insured's written request, furnish the insured the information that the insurer or insurance producer used to make its decision.~~ A notice is not effective unless it contains adequate information about the insured's right to make the request.

(2) This section does not apply if the ground for cancellation or nonrenewal is nonpayment of the premium and the reason is stated in the notice so states."

Section 27. Section 33-16-102, MCA, is amended to read:

"33-16-102. Definitions. In this chapter, the following definitions apply:

(1) "Advisory organization" means ~~every~~ each person, other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans, or rating systems or ~~which~~ who collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a ratemaking, capacity. ~~No duly authorized~~ A licensed attorney at law, acting in the usual course of his the profession, ~~shall may not be deemed to be considered~~ an advisory organization.

(2) "Dividend" means:

(a) a noncontractual and nonrecoverable payment or credit declared by an insurer's board of directors and paid out or credited out of earned surplus to policyholders, members, or subscribers; or

(b) in the absence of earned surplus, a noncontractual and nonrecoverable payment or credit declared by an insurer's board of directors and paid to policyholders, members, or subscribers with the written permission of the commissioner. The commissioner may grant permission only if the payment of the dividend or credit will not reduce the insurer's capital below an amount three times the minimum capital required under 33-2-109.

~~(2)~~(3) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory, or other organization.

~~(3)~~(4) "Rating organization" means ~~every~~ each person, other than an admitted insurer, whether located within or outside this state, ~~who has as his~~ with the object or purpose the of making of rates, rating plans, or rating systems. Two or more admitted insurers ~~which~~ who act in concert for the purpose of making rates, rating plans, or rating systems and ~~which~~ who do not operate within the specific authorizations contained in 33-16-105, 33-16-302, 33-16-304, 33-16-305, and 33-16-307 ~~shall must~~ be ~~deemed to be~~ considered a rating organization. ~~No~~ A single insurer ~~shall may not~~ be ~~deemed to be~~ considered a rating organization.

~~(4)~~(5) "Subscriber" means an insurer ~~which~~ who is furnished at its request with rates and rating manuals by a rating organization of which ~~it~~ the insurer is not a member or with advisory services by an advisory organization of which it is not a member.

~~(5)~~(6) "Willful" or "willfully", in relation to an act or omission ~~which~~ that constitutes a violation of this chapter, means with actual knowledge or belief that ~~such~~ the act or omission constitutes ~~such~~ a violation and with specific intent to commit ~~such~~ the violation."

Section 28. Section 33-16-104, MCA, is amended to read:

"33-16-104. Payment of dividends, savings, or unabsorbed premium deposits not prohibited or regulated -- plan for payment not rating system. Nothing in this chapter ~~shall may~~ be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers ~~shall may~~ not be ~~deemed~~ considered a rating plan or system. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders,

members, or subscribers does not relieve the insurer from complying with any requirements of this chapter regarding rating plans or systems."

Section 29. Section 33-16-1021, MCA, is amended to read:

"33-16-1021. Ratemaking standards -- review by commissioner. (1) Rates may not be excessive, inadequate, or unfairly discriminatory.

(2) Rates in a competitive market are not excessive. Rates in a noncompetitive market are excessive if they are likely to produce a long-run profit that is unreasonably high in relation to services rendered.

(3) A rate may not be determined to be inadequate unless:

(a) it is clearly insufficient to sustain projected losses and expenses; and

(b) the rate is unreasonably low and the use of the rate by the insurer has had or, if continued, will tend to create a monopoly in the market; or

(c) funds equal to the full, ultimate cost of anticipated losses and loss adjustment expenses are not produced when prospective loss costs are applied to anticipated payrolls.

(4) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with different loss exposures or expense levels.

(5) In determining whether rates comply with standards under subsection (1), consideration must be given to:

(a) past and prospective loss experience within and outside Montana, in accordance with accepted actuarial principles;

(b) catastrophe hazards and contingencies;

(c) past and prospective expenses within and outside Montana;

(d) loadings for leveling premium rates over time for dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers;

(e) a reasonable margin for underwriting profit; and

(f) all other relevant factors within and outside Montana.

(6) The systems of expense provisions included in the rates for use by an insurer or group of

insurers may differ from those of any other insurer or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers.

(7) The rate may contain provisions of contingencies and an allowance permitting a reasonable profit. In determining the reasonableness of a profit, consideration must be given to all investment income attributable to premiums and the reserves associated with those premiums.

(8) The commissioner may investigate and determine whether rates in Montana are excessive, inadequate, or unfairly discriminatory. In any investigation and determination, the commissioner shall also consider the factors specified in 33-16-1020."

Section 30. Section 33-16-1022, MCA, is amended to read:

"33-16-1022. Dividends -- ~~no regulation or prohibition.~~ (1) An advisory organization may not adopt a rule that would regulate or prohibit the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

(2) A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers is not a rating plan or system. A plan for the payment of dividends, savings, or unabsorbed premium deposits does not relieve an insurer from complying with any requirement of this chapter regarding rating plans or systems.

(3) It is an unfair trade practice under 33-18-1003 to make the payment of a dividend or any portion of it conditioned upon renewal of the policy or contract."

Section 31. Section 33-17-212, MCA, is amended to read:

"33-17-212. Examination required -- exceptions -- fees. (1) Except as provided in subsection (7), an individual applying for a license shall pass a written examination. The examination must test the knowledge of the individual concerning each kind of insurance listed in subsection (6) for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state. The examination must be developed and conducted under rules adopted by the commissioner.

(2) The commissioner may conduct the examination or make arrangements, including contracting with an outside testing service, for administering the examination and collecting the fees required by

33-2-708. The commissioner may arrange for the testing service to recover the cost of the examination from the applicant.

(3) Each individual applying for an examination shall remit the fees required by 33-2-708.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination may reapply for an examination and shall remit all required fees and forms before being rescheduled for another examination.

(5) ~~If the applicant is a~~ If the applicant is a partnership or corporation, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall take the examination, each individual who is to be named in the license as having authority to act for the applicant in its insurance transactions under the license shall meet the qualifications as provided in this section.

(6) Examination of an applicant for a license must cover all of the kinds of insurance for which the applicant has applied to be licensed, as constituted by any one or more of the following classifications:

(a) life insurance;

(b) disability insurance;

(c) property insurance. For the purposes of this provision, property insurance includes marine insurance.

(d) casualty insurance;

(e) surety insurance;

(f) credit life and disability insurance;

(g) title insurance.

(7) This section does not apply to and an examination is not required of:

(a) an individual lawfully licensed as an insurance producer as to the kind or kinds of insurance to be transacted as of or immediately prior to January 1, 1961, and who continues to be licensed;

(b) an applicant for a license covering the same kind or kinds of insurance as to which the applicant was licensed in this state, other than under a temporary license, within the 12 months immediately preceding the date of application unless the commissioner has suspended, revoked, or refused to continue the previous license, except that this subsection (7)(b) does not apply to a title

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insurance producer, as defined in 33-25-105;

- (c) an applicant for a license as a nonresident insurance producer;
- (d) an applicant for a license to sell all-risk federal crop insurance if the applicant provides certification from an appropriate governmental agency to the commissioner that the applicant is qualified to sell the insurance;
- (e) transportation ticket agents of common carriers applying for a license to solicit and sell only:
 - (i) accident insurance ticket policies; or
 - (ii) insurance of personal effects while being carried as baggage on a common carrier, as incidental to their duties as transportation ticket agents;
- (f) an association applying for a license under 33-17-211;
- (g) a mechanical breakdown insurance producer;
- ~~(h) a service contract insurance producer; or~~
- (h) a prepaid legal plans producer;
- (i) a gap insurance producer;
- (j) involuntary unemployment insurance producer; or
- ~~(k)~~ (k) an individual who, within 60 days of cancellation of a license issued by the state of the individual's residence, files with the commissioner a current letter of clearance certifying that the individual has passed an examination and held an insurance license in good standing in the individual's state of licensure, except that the individual shall take an examination pertaining to this state's law and each kind of insurance for which the individual has applied for a license and that is not covered under the license held in the other state."

Section 32. Section 33-17-236, MCA, is amended to read:

"33-17-236. Appointments of insurance producers by insurers. (1) An insurance producer may not claim to be a representative of or an authorized or appointed insurance producer of or use another term implying a contractual relationship with a particular insurer ~~and may not accept applications for the insurer unless the insurance producer becomes~~ is an appointed insurance producer of that insurer pursuant to this section. ~~The following are the appointing insurer's requirements for making appointment of a licensed insurance producer:~~ This does not prevent an insurance producer from obtaining and presenting

a quotation from an insurer with whom the producer is not appointed. If the insurer consents, the insurer may bind coverage on a risk in accordance with 33-15-411 prior to the execution of an agency contract and policy issuance.

~~{a}~~(2) The insurer shall, ~~no~~ not later than 15 days from the date on which the agency contract is executed ~~or the first insurance application is submitted by~~ with a licensed insurance producer, ~~whichever is earlier,~~ file with the insurance department a written notice of appointment on a form prescribed by the insurance department. The notice may be electronically filed pursuant to rules adopted by the commissioner.

~~—— (b) If there is no executed agency contract, the insurer shall mail to the licensed insurance producer, no later than 15 days from the date the first insurance application is submitted by him, a copy of the notice of appointment form filed with the insurance department. If the licensed insurance producer does not receive the acknowledgment of appointment from the insurer within 30 days from the date the first insurance application is submitted to the insurer, the insurance producer shall immediately discontinue acting as an insurance producer on behalf of that insurer until the acknowledgment is received or the agency contract is executed.~~

~~{2}~~(3) Upon receipt of the notice of appointment, the insurance department shall verify ~~within 5 working days~~ that the licensed insurance producer is eligible for appointment. If the licensed insurance producer is determined to be ineligible for appointment, the insurance department shall notify the insurer ~~within 5 days~~ of the determination.

~~{3}~~(4) An appointment is effective on the earlier of the date of the executed agency contract and or the date on which the insurer files the notice of appointment with the insurance department, unless the appointment is disapproved by the insurance department. A disapproved appointment is void on the date the department provides notification to the insurer.

(5) The appointment is perpetual until canceled by the insurer."

Section 33. Section 33-17-505, MCA, is amended to read:

"33-17-505. **Qualification -- fee.** (1) In order to determine the competency of an applicant for a consultant license, the commissioner shall require the applicant to pass an examination.

(2) The commissioner may conduct the examination or make arrangements, including contracting

with an outside testing service, for administering the examination and collecting the fees required by 33-17-503. The commissioner may arrange for the testing service to recover its cost of the examination from the applicant.

~~(2)~~(3) The fee for taking the consultant license examination is \$50. The commissioner shall deposit all fees collected in the general fund. The fee for taking a second or subsequent examination may be no more than the cost of administering the examination, not to exceed \$50."

Section 34. Section 33-17-507, MCA, is amended to read:

"33-17-507. Revocation. The commissioner may revoke or suspend a consultant license for a specified period ~~he determines if, after giving notice and conducting a hearing, as specified in this chapter, he~~ To revoke or suspend a license, the commissioner shall ~~determines~~ determine that the licensee:

- (1) has violated any provision of or any obligation imposed by the insurance law or has violated any law in the course of ~~his dealings~~ dealing as an insurance consultant;
- (2) has made a material misstatement in application for a consultant license;
- (3) has been guilty of fraudulent or dishonest practices; or
- (4) has demonstrated ~~his~~ incompetency or untrustworthiness to act as an insurance consultant."

Section 35. Section 33-17-1203, MCA, is amended to read:

"33-17-1203. Continuing education -- basic requirements -- exceptions. (1) Unless exempt under subsection (4):

- (a) a person licensed to act as an insurance producer for property, casualty, surety, or title insurance or as a consultant for general insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;
- (b) a person licensed to act as an insurance producer for life or disability insurance or as a consultant for life insurance shall, during each calendar year, complete at least 10 credit hours of approved continuing education;
- (c) a person holding multiple licenses shall, during each calendar year, complete at least 15 credit hours of approved continuing education;

(d) a person licensed to act as an insurance producer only for credit life and disability insurance shall, during each calendar year, complete ~~5~~ 2 1/2 credit hours of approved continuing education in the areas of insurance law, ethics, or credit life and disability insurance;

(e) a person licensed as an insurance producer or consultant shall, during each biennium, complete at least 1 credit hour of approved continuing education on changes in Montana insurance statutes and administrative rules.

(2) If a person licensed as an insurance producer or consultant completes more credit hours of approved continuing education in a year than the minimum required in subsection (1), the excess credit hours may be carried forward and applied to the continuing education requirements of the next year.

(3) The commissioner may, for good cause, grant an extension of time, not to exceed 1 year, during which the requirements imposed by subsection (1) may be completed.

(4) The minimum continuing education requirements do not apply to:

(a) a person licensed to sell any kind of insurance for which an examination is not required under 33-17-212(7)(d) through ~~(7)(h)~~ (7)(k);

(b) a person holding a temporary license issued under 33-17-216;

(c) a nonresident licensee who must meet continuing education requirements in the licensee's state of residence if that state grants substantially similar privileges to and has similar requirements for residents of this state;

(d) a newly licensed insurance producer or consultant during the calendar year in which the licensee first received a license;

(e) a person who only executes surety bail bonds; or

(f) an insurance producer or consultant otherwise exempted by the commissioner."

Section 36. Section 33-18-301, MCA, is amended to read:

"33-18-301. Prohibited relations with mortuaries. (1) A life insurer and its board of directors, officers, employees, or representatives may not own, manage, supervise, operate, or maintain any mortuary, funeral, or undertaking establishment in Montana.

(2) A life insurer may not contract or agree with any funeral director, mortuary, or undertaker that the funeral director, undertaker, or mortuary shall conduct the funeral or be named beneficiary of any

person insured by the insurer. This subsection does not prohibit a life insurer from making insurance, designated as funeral insurance, available.

(3) A funeral insurance policy and any solicitation material for the policy must clearly indicate that:

- (a) the policy is a life insurance product;
- (b) the applicant may designate the beneficiary, ~~provided that~~ if there is an appropriate and insurable interest;
- (c) the beneficiary may use the proceeds for any purpose; and
- (d) any attempt by the insurer or its representative to have the insured designate a specific beneficiary, including but not limited to a funeral director, mortuary, or undertaker, constitutes a violation of this section punishable as a misdemeanor pursuant to subsection (4).

(4) Each violation of this section constitutes a misdemeanor punishable by a fine of not more than \$1,000 or by imprisonment for not more than 6 months, or both."

Section 37. Section 33-18-1006, MCA, is amended to read:

"33-18-1006. Desist orders for prohibited practices. Violations of 33-18-221 through ~~33-18-223~~ 33-18-224 are subject to cease and desist orders of the commissioner issued under 33-18-1004."

Section 38. Section 33-20-121, MCA, is amended to read:

"33-20-121. Prohibited provisions -- limitations on liability. (1) A policy of life insurance may not be delivered or issued for delivery in this state if it contains a provision:

- (a) for a period shorter than that provided by statute within which an action at law or in equity may be commenced on the policy; or
- (b) that excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified in the policy in the event of death:

- (i) as a result, directly or indirectly, of war, declared or undeclared, or of action by military forces or of an act or hazard of war or action or of service in the military, naval, or air forces or in civilian forces auxiliary to those military forces or from any cause while a member of military, naval, or air forces of a

country at war, declared or undeclared, or of a country engaged in military action;

(ii) as a result of aviation, air travel, or flight;

(iii) as a result of a specified hazardous occupation or occupations;

(iv) while the insured is a resident outside the continental United States and Canada; or

(v) within 2 years from the date of issue of the policy as a result of suicide, ~~while committed pursuant to 53-21-127~~. If a life insurance policy contains a dependent rider, the dependent coverage may be continued upon payment of the premium for the dependent rider.

(2) A policy that contains an exclusion or restriction pursuant to subsection (1) must also provide that in the event of death under the circumstances to which the exclusion or restriction is applicable, the insurer will pay an amount not less than a reserve determined according to the commissioner's reserve valuation method on the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits ~~for, if the policy does not provide for nonforfeiture benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy~~ or by any other method more favorable to the policyholder, with adjustment for indebtedness or dividend credit.

(3) This section does not apply to industrial life insurance, group life insurance, disability insurance, reinsurance, or annuities or to a provision in a life insurance policy relating to disability benefits or to additional benefits in the event of death by accident or accidental means.

(4) This section does not prohibit a provision that in the opinion of the commissioner is more favorable to the policyholder than a provision permitted by this section."

Section 39. Section 33-20-1201, MCA, is amended to read:

"33-20-1201. Provisions required in group contracts. ~~No~~ A policy of group life insurance ~~shall~~ may not be delivered in this state unless it contains in substance the provisions set forth in ~~33-20-1202 through 33-20-1211~~ this part or provisions ~~which~~ that in the opinion of the commissioner are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder, ~~except, however, that:~~

(1) ~~sections 33-20-1207 through 33-20-1211~~ shall do not apply to policies issued to a creditor to insure debtors of ~~such~~ the creditor;

(2) the standard provisions required for individual life insurance policies ~~shall~~ do not apply to group life insurance policies; and

(3) If the group life insurance policy is on a plan of insurance other than the term plan, it ~~shall~~ must contain a nonforfeiture provision or provisions ~~which that~~ in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but nothing ~~herein shall~~ in this subsection may be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies."

Section 40. Section 33-22-101, MCA, is amended to read:

"**33-22-101. Exceptions to scope.** Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-130 through ~~33-22-132, 33-22-134,~~ 33-22-135, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter, do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance as:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to ~~safeguard~~ contracts ~~against lapse~~ or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

Section 41. Section 33-22-111, MCA, is amended to read:

"**33-22-111. Policies to provide for freedom of choice of practitioners -- professional practice not enlarged.** (1) All policies of disability insurance, including individual, group, and blanket policies, must provide that the insured has full freedom of choice in the selection of any licensed physician, physician assistant-certified, dentist, osteopath, chiropractor, optometrist, podiatrist, psychologist, licensed social

worker, licensed professional counselor, acupuncturist, or ~~nurse-specialist~~ advanced practice registered nurse as specifically listed in 37-8-202 for treatment of any illness or injury within the scope and limitations of the person's practice. Whenever the policies insure against the expense of drugs, the insured has full freedom of choice in the selection of any licensed and registered pharmacist.

(2) This section may not be construed as enlarging the scope and limitations of practice of any of the licensed professions enumerated in subsection (1). This section may not be construed as amending, altering, or repealing any statutes relating to the licensing or use of hospitals."

Section 42. Section 33-22-140, MCA, is amended to read:

"33-22-140. Definitions. As used in this chapter, unless the context requires otherwise, the following definitions apply:

(1) "Beneficiary" has the meaning given the term by 29 U.S.C. 1002(33).

(2) "Church plan" has the meaning given the term by 29 U.S.C. 1002(33).

(3) "COBRA continuation provision" means:

(a) section 4980B of the Internal Revenue Code, 26 U.S.C. 4980B, other than subsection (f)(1) of that section as it relates to pediatric vaccines;

(b) Title I, subtitle B, part 6, excluding section 609, of the Employee Retirement Income Security Act of 1974, Public Law 93-406; or

(c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.

(4) (a) "Creditable coverage" means coverage of the individual under any of the following:

(i) a group health plan;

(ii) health insurance coverage;

(iii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;

(iv) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;

(v) Title 10, chapter 55, United States Code;

(vi) a medical care program of the Indian health service or of a tribal organization;

(vii) the Montana comprehensive health association provided for in 33-22-1503;

(viii) a health plan offered under Title 5, chapter 89, of the United States Code;

(ix) a public health plan;

(x) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e).

(b) Creditable coverage does not include coverage consisting solely of coverage of excepted benefits.

(5) "Elimination rider" means a provision attached to a policy that excludes coverage for a specific condition that would otherwise be covered under the policy.

(6) "Enrollment date" means, with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for enrollment.

(7) "Excepted benefits" means:

(a) coverage only for accident, or disability income insurance, or both;

(b) coverage issued as a supplement to liability insurance;

(c) liability insurance, including general liability insurance and automobile liability insurance;

(d) workers' compensation or similar insurance;

(e) automobile medical payment insurance;

(f) credit-only insurance;

(g) coverage for onsite medical clinics;

(h) other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits, as approved by the commissioner;

(i) if offered separately, any of the following:

(i) limited-scope dental or vision benefits;

(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these types of care; or

(iii) other similar, limited benefits as approved by the commissioner;

(j) if offered as independent, noncoordinated benefits, any of the following:

(i) coverage only for a specified disease or illness; or

(ii) hospital indemnity or other fixed indemnity insurance;

(k) if offered as a separate insurance policy;

- (i) medicare supplement coverage;
 - (ii) coverage supplemental to the coverage provided under Title 10, chapter 55, of the United States Code; and
 - (iii) similar supplemental coverage provided under a group health plan.
- (8) "Federally defined eligible individual" means an individual:
- (a) for whom, as of the date on which the individual seeks coverage in the group market or individual market or under an association portability plan, as defined in 33-22-1501, the aggregate of the periods of creditable coverage is 18 months or more;
 - (b) whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any of those plans;
 - (c) who is not eligible for coverage under:
 - (i) a group health plan;
 - (ii) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-4 or 42 U.S.C. 1395j through 1395w-4; or
 - (iii) a state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or a successor program;
 - (d) who does not have other health insurance coverage;
 - (e) for whom the most recent coverage within the period of aggregate creditable coverage was not terminated for factors relating to nonpayment of premiums or fraud;
 - (f) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and
 - (g) who has exhausted continuation coverage under the COBRA continuation provision or program described in subsection (8)(f) if the individual elected the continuation coverage described in subsection (8)(f).
- (9) "Group health insurance coverage" means health insurance coverage offered in connection with a group health plan or health insurance coverage offered to an eligible group as described in 33-22-501.
- (10) "Group health plan" means an employee welfare benefit plan, as defined in, 29 U.S.C. 1002(1), to the extent that the plan provides medical care and items and services paid for as medical care

to employees or their dependents, directly or through insurance, reimbursement, or otherwise.

(11) "Health insurance coverage" means benefits consisting of medical care, including items and services paid for as medical care, that are provided directly, through insurance, reimbursement, or otherwise, under a policy, certificate, membership contract, or health care services agreement offered by a health insurance issuer.

(12) "Health insurance issuer" means an insurer, a health service corporation, or a health maintenance organization.

(13) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.

(14) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan insurance coverage.

(15) "Large employer" means, in connection with a group health plan, with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

(16) "Large group market" means the health insurance market under which individuals obtain health insurance coverage directly or through any arrangement on behalf of themselves and their dependents through a group health plan or group health insurance coverage issued to a large employer ~~maintained by a large employer~~.

(17) "Late enrollee" means an eligible employee or dependent, other than a special enrollee under 33-22-523, who requests enrollment in a group health plan following the initial enrollment period during which the individual was entitled to enroll under the terms of the group health plan if the initial enrollment period was a period of at least 30 days. However, an eligible employee or dependent is not considered a late enrollee if:

~~(a) the individual requests enrollment within 63 days after termination of the creditable coverage and:~~

~~(i) the individual was covered under creditable coverage at the time of the initial enrollment; or~~

~~(ii) the individual lost coverage under creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination of the creditable~~

~~coverage, the death of a spouse, divorce, or legal separation;~~

~~—— (b) the individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or~~

~~—— (c) a court has ordered that coverage be provided for a spouse, minor, or dependent child under a covered employee's health benefit plan and a request for enrollment is made within 30 days after issuance of the court order.~~

(18) "Medical care" means:

(a) the diagnosis, cure, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(b) transportation primarily for and essential to medical care referred to in subsection (18)(a); or

(c) insurance covering medical care referred to in subsections (18)(a) and (18)(b).

(19) "Network plan" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer.

(20) "Plan sponsor" has the meaning provided under section 3(16)(B) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1002(16)(B).

(21) "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date.

(22) "Small group market" means the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan or group health insurance coverage maintained by a small employer as defined in 33-22-1803 ~~maintained by a small employer, as defined in 33-22-1803.~~

(23) "Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan."

Section 43. Section 33-22-307, MCA, is amended to read:

"33-22-307. Continuity of coverage. (1) Subject to the requirements of 33-22-305 through 33-22-311 and on the date specified in the policy under which coverage otherwise terminates because of the death of the named insured or for any other reason specified in 33-22-306, as to covered family members, other than for nonpayment of premium, nonrenewal of the policy, or the expiration of the term for which the policy is issued, a covered person, ~~other than one eligible for medicare or any other similar federal or state disability insurance program~~, including the spouse and any covered dependent child of the last-named insured or the representative of ~~such the~~ child, has the right to continuation of coverage under provisions that, at the option of the carrier, are consistent with:

(a) the continuation of the policy, with the person exercising the right of continuation designated as the named insured;

(b) the issuance of a converted policy with the person exercising the conversion right designated as the named insured; or

(c) both (1)(a) and (1)(b).

(2) When continuation of coverage or conversion is made in the name of the spouse of the named insured, the coverage may, at the option of the spouse, include covered dependent children for whom the spouse has the responsibility for care and support."

Section 44. Section 33-22-514, MCA, is amended to read:

"33-22-514. Preexisting conditions relating to group market. (1) A group health plan or a health insurance issuer offering group health insurance coverage may not exclude coverage for a preexisting condition unless:

(a) medical advice, diagnosis, care, or treatment was recommended or received by the participant or beneficiary within the 6-month period ending on the enrollment date;

(b) exclusion of coverage extends for a period of not more than 12 months or 18 months in the case of a late enrollee; and

(c) the period of the preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.

(2) Genetic information may not be excluded as a preexisting condition in the absence of a

diagnosis of the condition related to the genetic information.

(3) Pregnancy may not be excluded as a preexisting condition."

Section 45. Section 33-22-523, MCA, is amended to read:

"33-22-523. Special enrollment periods. (1) A group health plan and a health insurance issuer offering group health insurance coverage in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible, but not enrolled, for coverage under the terms of the group health plan to enroll for coverage under the terms of the group health plan if:

(a) the employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) the employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) the employee's or dependent's coverage described in subsection (1)(a) was:

(i) under a COBRA continuation provision and was exhausted; or

(ii) not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the coverage were terminated; and

(d) under the terms of the group health plan, the employee requests the enrollment not later than 30 days after the date of exhaustion of coverage described in subsection (1)(c)(i) or termination of coverage or employer contribution described in subsection (1)(c)(ii).

(2) (a) A group health plan ~~shall~~ must provide for a dependent special enrollment period described in subsection (2)(b) during which a dependent may be enrolled under the group health plan as a dependent of the individual ~~and, if the person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.~~ in ~~in~~ the case of the birth or adoption of a child, the spouse of the individual may be enrolled as a dependent of the individual if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period under this subsection (2) is a period of not less than 30 days that begins on the later of:

(i) the date dependent coverage is made available; or

(ii) the date of the marriage, birth, ~~or~~ adoption, or placement for adoption.

(3) If an individual seeks to enroll a dependent during the first 30 days of the dependent special enrollment period, the coverage of the dependent becomes effective:

(a) in the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) in the case of a dependent's birth, as of the date of birth; or

(c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption."

Section 46. Section 33-22-524, MCA, is amended to read:

"33-22-524. Guaranteed renewability of coverage for employers in group market. (1) Except as provided in this section, if a health insurance issuer offers health insurance coverage in the small group market or large group market in connection with a group health plan, the health insurance issuer shall renew or continue the coverage in force at the option of the plan sponsor.

(2) A health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small group market or large group market if:

(a) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage or if the health insurance issuer has not received timely premium payments;

(b) the plan sponsor has performed an act or practice that constitutes fraud or has made an intentional misrepresentation of material fact under the terms of the coverage;

(c) the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group health plan participation rules ~~in the case of the small group market or pursuant to applicable state law in the case of the large group market;~~

(d) the health insurance issuer is ceasing to offer coverage in that group market in accordance with this section and applicable state law;

(e) in the case of a health insurance issuer that offers health insurance coverage in the group market through a network plan, there is no longer any enrollee in connection with the group health plan who lives, resides, or works in the service area of the health insurance issuer and, in the case of the small

group market, if the health insurance issuer would deny enrollment with respect to the plan under 33-22-1811(4)(a)(i); or

(f) in the case of health insurance coverage that is made available in the small group market or large group market only through one or more bona fide associations, the membership of an employer in the bona fide association ceases, but only if the coverage is terminated under this subsection (2)(f) uniformly without regard to any health status-related factor of a covered individual.

(3) A health insurance issuer may not discontinue offering a particular type of group health insurance coverage offered in the small group market or large group market unless in accordance with applicable state law and unless:

(a) the issuer provides notice to each plan sponsor, participant, and beneficiary provided coverage of this type in that group market of the discontinuation at least 90 days prior to the date of the discontinuation of the coverage;

(b) the issuer offers to each plan sponsor provided coverage of this type in the market the option to purchase any other health insurance coverage currently being offered by the health insurance issuer to a group health plan in the market; and

(c) the health insurance issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor of any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for the coverage.

(4) (a) A health insurance issuer may not discontinue offering all health insurance coverage in the small group market, the large group market, or both the small group market and the large group market, unless in accordance with applicable state law and unless:

(i) the issuer provides notice of discontinuation to the commissioner and to each plan sponsor, participant, and beneficiary covered at least 180 days prior to the date of the discontinuation of coverage; and

(ii) all health insurance issued or delivered for issuance in Montana in the group market or markets is discontinued and coverage under the health insurance coverage in the group market or markets is not renewed.

(b) In the case of a discontinuation under this section in a group market, the health insurance issuer may not provide for the issuance of any health insurance coverage in the group market for a period

of 5 years beginning on the date of the discontinuation of the last health insurance coverage not renewed.

(5) A health insurance issuer may modify upon renewal health insurance coverage for a product offered to a group health plan in the large group market or in the small group market if, for coverage that is available in the small group market other than only through one or more bona fide associations, modification is consistent with applicable state law and effective on a uniform basis among group health plans with that product.

(6) In the case of health insurance coverage that is made available by a health insurance issuer in the small group market or large group market to employers only through one or more bona fide associations, references to "plan sponsor" under this section include those employers."

Section 47. Section 33-22-1803, MCA, is amended to read:

"33-22-1803. Definitions. As used in this part, the following definitions apply:

(1) "Actuarial certification" means a written statement by a member of the American academy of actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of 33-22-1809, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified entity or person.

(3) "Assessable carrier" means all carriers of disability insurance, including excess of loss and stop loss disability insurance.

(4) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(5) "Basic health benefit plan" means a health benefit plan, except a uniform health benefit plan, developed by a small employer carrier, that has a lower benefit value than the small employer carrier's standard benefit plan and that provides the benefits required by 33-22-1827.

(6) "Benefit value" means a numerical value based on the expected dollar value of benefits payable to an insured under a health benefit plan. The benefit value must be calculated by the small employer carrier using an actuarially based method and must take into account all health care expenses covered by the health benefit plan and all cost-sharing features of the health benefit plan, including deductibles, coinsurance, copayments, and the insured individual's maximum out-of-pocket expenses. The benefit value must apply equally to indemnity-type health benefit plans and to managed care health benefit plans, including health maintenance organization-type plans.

(7) "Board" means the board of directors of the program established pursuant to 33-22-1818.

(8) "Bona fide association" means an association that:

(a) has been actively in existence for at least 5 years;

(b) was formed and has been maintained in good faith for purposes other than obtaining insurance;

(c) does not condition membership in the association on a health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;

(d) makes health insurance coverage offered through the association available to a member regardless of a health status-related factor relating to the member or an individual eligible for coverage through a member; and

(e) does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

~~(f) meets any additional requirements required by law.~~

(9) "Carrier" means any person who provides a health benefit plan in this state subject to state insurance regulation. The term includes but is not limited to an insurance company, a fraternal benefit society, a health service corporation, and a health maintenance organization. For purposes of this part, companies that are affiliated companies or that are eligible to file a consolidated tax return must be treated as one carrier, except that the following may be considered as separate carriers:

(a) an insurance company or health service corporation that is an affiliate of a health maintenance organization located in this state;

(b) a health maintenance organization located in this state that is an affiliate of an insurance company or health service corporation; or

(c) a health maintenance organization that operates only one health maintenance organization in an established geographic service area of this state.

(10) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, provided that gender, claims experience, health status, and duration of coverage are not case characteristics for purposes of this part.

(11) "Class of business" means all or a separate grouping of small employers established pursuant to 33-22-1808.

(12) "Dependent" means:

(a) a spouse or an unmarried child under 19 years of age;

(b) an unmarried child, under 23 years of age, who is a full-time student and who is financially dependent on the insured;

(c) a child of any age who is disabled and dependent upon the parent as provided in 33-22-506 and 33-30-1003; or

(d) any other individual defined as a dependent in the health benefit plan covering the employee.

(13) "Eligible employee" means an employee who works on a full-time basis with a normal workweek of 30 hours or more, except that at the sole discretion of the employer, the term may include an employee who works on a full-time basis with a normal workweek of between 20 and 40 hours as long as this eligibility criteria is applied uniformly among all of the employer's employees. The term includes a sole proprietor, a partner of a partnership, and an independent contractor if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer. The term also includes those persons eligible for coverage under 2-18-704. The term does not include an employee who works on a part-time, temporary, or substitute basis.

(14) "Established geographic service area" means a geographic area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(15) "Health benefit plan" means any hospital or medical policy or certificate providing for physical and mental health care issued by an insurance company, a fraternal benefit society, or a health service corporation or issued under a health maintenance organization subscriber contract. Health benefit plan

does not include coverage of excepted benefits if coverage is provided under a separate policy, certificate, or contract of insurance.

(16) "Index rate" means, for each class of business for a rating period for small employers with similar case characteristics, the average of the applicable base premium rate and the corresponding highest premium rate.

(17) "New business premium rate" means, for each class of business for a rating period, the lowest premium rate charged or offered or that could have been charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(18) "Plan of operation" means the operation of the program established pursuant to 33-22-1818.

(19) "Premium" means all money paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with the health benefit plan.

(20) "Program" means the Montana small employer health reinsurance program created by 33-22-1818.

(21) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(22) "Reinsuring carrier" means a small employer carrier participating in the reinsurance program pursuant to 33-22-1819.

(23) "Restricted network provision" means a provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to Title 33, chapter 22, part 17, or Title 33, chapter 31, to provide health care services to covered individuals.

(24) "Small employer" means a person, firm, corporation, partnership, or bona fide association that is actively engaged in business and that, with respect to a calendar year and a plan year, employed at least 2 but not more than 50 eligible employees during the preceding calendar year and employed at least two employees on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer must be based on the average number of employees reasonably expected to be employed by

the employer in the current calendar year. In determining the number of eligible employees, companies are considered one employer if they:

- (a) are affiliated companies;
- (b) are eligible to file a combined tax return for purposes of state taxation; or
- (c) are members of a bona fide association.

(25) "Small employer carrier" means a carrier that offers health benefit plans that cover eligible employees of one or more small employers in this state.

(26) "Standard health benefit plan" means a health benefit plan that is developed by a small employer carrier and that contains the provisions required pursuant to 33-22-1828."

Section 48. Section 33-22-1809, MCA, is amended to read:

"33-22-1809. Restrictions relating to premium rates. (1) Premium rates for health benefit plans under this part are subject to the following provisions:

(a) The index rate for a rating period for any class of business may not exceed the index rate for any other class of business by more than 20%.

(b) For each class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to the employer under the rating system for that class of business may not vary from the index rate by more than 25% of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers;

(ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods of less than 1 year, because of the claims experience, health status, or duration of coverage of the employees

or dependents of the small employer, as determined from the small employer carrier's rate manual for the class of business; and

(iii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents. Any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) If a small employer carrier uses industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification may not vary from the average of the rate factors associated with all industry classifications by more than 15% of that coverage.

~~(f) In the case of health benefit plans delivered or issued for delivery prior to January 1, 1994, a premium rate for a rating period may exceed the ranges set forth in subsections (1)(a) and (1)(b) until January 1, 1997. In that case, the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:~~

~~—— (i) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers; and~~

~~—— (ii) any adjustment because of a change in coverage or a change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.~~

~~(g)~~(f) A small employer carrier shall:

(i) apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors must produce premiums for identical groups that differ only by the amounts attributable to plan design and that do not reflect differences because of the nature of the groups. Differences among base premium rates may not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(ii) treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

~~(h)~~(g) For the purposes of this subsection (1), a health benefit plan that includes a restricted network provision may not be considered similar coverage to a health benefit plan that does not include a restricted network provision.

(2) A small employer carrier may not transfer a small employer involuntarily into or out of a class of business. A small employer carrier may not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claims experience, health status, or duration of coverage since the insurance was issued.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) for the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension would enhance the fairness and efficiency of the small employer health insurance market.

(4) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of each of the following:

(a) the extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or upon the actual or expected variation in health status of the employees of small employers and the employees' dependents;

(b) the provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and the factors, other than claims experience, that affect changes in premium rates;

(c) the provisions relating to renewability of policies and contracts; and

(d) the provisions relating to any preexisting condition.

(5) (a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and

documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the commissioner annually, on or before March 15, an actuarial certification certifying that the carrier is in compliance with this part and that the rating methods of the small employer carrier are actuarially sound. The actuarial certification must be in a form and manner and must contain information as specified by the commissioner. A copy of the actuarial certification must be retained by the small employer carrier at its principal place of business.

~~(c) The filing required in subsection (5)(b) must contain the small employer carrier's benefit value.~~

~~(d)~~ A small employer carrier shall make the information and documentation described in subsection (5)(a) available to the commissioner upon request. Except in cases of violations of the provisions of this part and except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction, the information must be considered proprietary and trade secret information and is not subject to disclosure by the commissioner to persons outside of the department.

(6) The commissioner may not require prior approval of the rating methods used by small employer carriers or the premium rates of the health benefit plans offered to small employers."

Section 49. Section 33-22-1811, MCA, is amended to read:

"33-22-1811. Availability of coverage -- required plans. (1) (a) As a condition of transacting business in this state with small employers, each small employer carrier must have approved for issuance to small employer groups at least two health benefit plans. One plan must be a basic health benefit plan, and one plan must be a standard health benefit plan.

(b) (i) A small employer carrier shall issue ~~a basic health benefit plan or a standard health benefit plan~~ all plans marketed under this part to any eligible small employer that applies for ~~either a plan and~~ either a plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this part. ~~If, pursuant to Public Law 104-191, an agency of the United States or a court does not prohibit a small employer carrier from doing so, a small employer carrier may offer and issue a group health benefit plan other than a basic or standard plan on an underwritten basis.~~

(ii) In the case of a small employer carrier that establishes more than one class of business

pursuant to 33-22-1808, the small employer carrier shall maintain and offer to eligible small employers ~~at least one basic health benefit plan and at least one standard health benefit plan~~ all plans marketed under this part in each established class of business. A small employer carrier may apply reasonable criteria in determining whether to accept a small employer into a class of business, provided that:

(A) the criteria are not intended to discourage or prevent acceptance of small employers applying for a health benefit plan;

(B) the criteria are not related to the health status or claims experience of the small employers' employees;

(C) the criteria are applied consistently to all small employers that apply for coverage in that class of business; and

(D) the small employer carrier provides for the acceptance of all eligible small employers into one or more classes of business.

(iii) The provisions of subsection (1)(b)(ii) may not be applied to a class of business into which the small employer carrier is no longer enrolling new small businesses.

(c) A small employer carrier that elects not to comply with the requirements of subsections (1)(a) and (1)(b) may continue to provide coverage under health benefit plans previously issued to small employers in this state for a period of no more than 7 years from October 1, 1995, if the carrier:

(i) complies with all other applicable provisions of this part, except 33-22-1810, 33-22-1813, and subsections (2) through (4) of this section; ~~and~~

(ii) does not amend or alter the benefits and coverages of the previously issued health benefit plans unless required to do so by law or rule; and

(iii) complies with all applicable provisions of Public Law 104-91.

(2) (a) A small employer carrier shall, pursuant to 33-1-501, file the basic health benefit plans and the standard health benefit plans to be used by the small employer carrier.

(b) The commissioner may at any time, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this part.

(3) Health benefit plans covering small employers must comply with the following provisions:

(a) A health benefit plan may not:

(i) because of a preexisting condition, deny, exclude, or limit benefits for a covered individual for losses incurred more than 12 months following the ~~effective date of the individual's~~ enrollment date coverage. A health benefit plan may not define a preexisting condition exclusion more restrictively than 33-22-140.

(ii) use a preexisting condition exclusion more restrictive than exclusions allowed under 33-22-514.

(b) A health benefit plan must waive any time period applicable to a preexisting condition exclusion or limitation period with respect to particular services for the period of time that an individual was previously covered by creditable coverage that provided benefits with respect to those services if the creditable coverage was continuous to a date not more than 63 days prior to the submission of an application for new coverage. A health benefit plan may determine waivers of time periods applicable to preexisting condition exclusions or limitations on the basis of prior coverage of benefits within each of several classes or categories as specified in regulations implementing Public Law 104-191, rather than as provided in this subsection (3)(b). This subsection (3)(b) does not preclude application of any waiting period applicable to all new enrollees under the health benefit plan.

(c) A health benefit plan may exclude coverage for late enrollees for 18 months or for an 18-month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period may not exceed 18 months from the date on which the individual enrolls for coverage under the health benefit plan.

(d) (i) Requirements used by a small employer carrier in determining whether to provide coverage to a small employer, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employers that have the same number of eligible employees and that apply for coverage or receive coverage from the small employer carrier.

(ii) A small employer carrier may vary the application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

(e) (i) If a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all of the eligible employees of a small employer and their dependents. A small employer carrier may not offer coverage only to certain individuals in a small employer group or only to part of the group, except in the case of late enrollees as provided in subsection (3)(c).

(ii) A small employer carrier may not modify a ~~basic or standard health benefit plan~~ marketed under

this part with respect to a small employer or any eligible employee or dependent, through riders, endorsements, or otherwise, to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

(iii) A small employer carrier shall secure a waiver of coverage from each eligible employee who declines, at the sole discretion of the eligible employee, an offer of coverage under a health benefit plan provided by the small employer. The waiver must be signed by the eligible employee and must certify that the employee was informed of the availability of coverage under the health benefit plan and of the penalties for late enrollment. The waiver may not require the eligible employee to disclose the reasons for declining coverage.

(iv) A small employer carrier may not issue coverage to a small employer if the carrier or a producer for the carrier has evidence that the small employer induced or pressured an eligible employee to decline coverage due to the health status or risk characteristics of the eligible employee or of the dependents of the eligible employee.

(4) (a) A small employer carrier may not be required to offer coverage or accept applications pursuant to subsection (1) in the case of the following:

(i) to an employer whose employees do not work or reside within the small employer carrier's established geographic service area for a network plan, as defined in 33-22-140; or

(ii) within an area where the small employer carrier reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its established geographic service area to deliver service adequately to the members of a group because of its obligations to existing group policyholders and enrollees. The small employer carrier may not deny coverage under this subsection unless the small employer carrier acts uniformly without regard to claims experience or health status-related factors of employers, employees, or dependents.

(b) A small employer carrier may not be required to provide coverage to small employers pursuant to subsection (1) for which the commissioner determines that the small employer carrier does not have the financial reserves necessary to underwrite additional coverage and that the small employer carrier has denied coverage of small employers uniformly throughout the state and without regard to the claims experience and health status-related factors of the applicant small employer groups. The small employer carrier exempted from providing coverage under this subsection may not offer coverage to small employer

groups in this state for 180 days after the date on which coverage is denied or until the small employer carrier has demonstrated to the commissioner that the small employer carrier has sufficient financial reserves to underwrite additional coverage, whichever is later."

Section 50. Section 33-22-1813, MCA, is amended to read:

"33-22-1813. Standards to ensure fair marketing. (1) Each small employer carrier shall actively market health benefit plan coverage, including the basic and standard health benefit plans, to eligible small employers in the state. ~~If a small employer carrier denies coverage other than the basic or standard health benefit plans to a small employer on the basis of claims experience of the small employer or the health status or claims experience of its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan or a standard health benefit plan.~~

(2) (a) Except as provided in subsection (2)(b), a small employer carrier or producer may not directly or indirectly engage in the following activities:

(i) encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer;

(ii) encouraging or directing small employers to seek coverage from another carrier because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) The provisions of subsection (2)(a) do not apply with respect to information provided by a small employer carrier or producer to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(3) (a) Except as provided in subsection (3)(b), a small employer carrier may not, directly or indirectly, enter into any contract, agreement, or arrangement with a producer that provides for or results in the compensation paid to a producer for the sale of a health benefit plan to be varied because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employer.

(b) Subsection (3)(a) does not apply with respect to a compensation arrangement that provides compensation to a producer on the basis of the percentage of a premium, provided that the percentage

may not vary because of the health status of the employer's employees or the claims experience, industry, occupation, or geographic area of the small employer.

(4) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a basic or standard health benefit plan.

(5) A small employer carrier may not terminate, fail to renew, or limit its contract or agreement of representation with a producer for any reason related to the health status of the employer's employees or the claims experience, industry, occupation, or geographic location of the small employers placed by the producer with the small employer carrier.

(6) A small employer carrier or producer may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(7) Denial by a small employer carrier of ~~an application for coverage from~~ health insurance coverage for a small employer must be in writing and must state the reason or reasons for the denial.

(8) The commissioner may adopt rules setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(9) (a) A violation of this section by a small employer carrier or a producer is an unfair trade practice under 33-18-102.

(b) If a small employer carrier enters into a contract, agreement, or other arrangement with an administrator who holds a certificate of registration pursuant to 33-17-603 to provide administrative, marketing, or other services related to the offering of health benefit plans to small employers in this state, the administrator is subject to this section as if the administrator were a small employer carrier."

Section 51. Section 33-22-1815, MCA, is amended to read:

"33-22-1815. **Qualifications for voluntary purchasing pool.** A voluntary purchasing pool of disability insurance purchasers may be formed solely for the purpose of obtaining disability insurance upon compliance with the following provisions:

(1) It contains at least 1,000 eligible employees.

(2) It establishes requirements for membership. The voluntary purchasing pool shall accept for membership any small employers and may accept for membership any employers with more than ~~25~~ 50

eligible employees that otherwise meet the requirements for membership. However, the voluntary purchasing pool may not exclude any small employers that otherwise meet the requirements for membership on the basis of claim experience, occupation, or health status.

(3) It holds an open enrollment period at least once a year during which new members can join the voluntary purchasing pool.

(4) It offers coverage to eligible employees of member employers and to the employees' dependents. Coverage may not be limited to certain employees of member small employers except as provided in 33-22-1811(3)(c).

(5) It does not assume any risk or form self-insurance plans among its members.

(6) (a) It has the option of using the following types of rating arrangements with the disability insurance policies, certificates, or contracts:

(i) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool that rate each member employer separately are subject to the provisions of this part.

(ii) Disability insurance policies, certificates, or contracts offered through the voluntary purchasing pool that rate the entire group as a whole must charge each insured person based on a community rate within the common group, adjusted for case characteristics as permitted by the laws governing group disability insurance.

(b) At its discretion, premiums may be paid to the disability insurance policies, certificates, or contracts by the voluntary purchasing pool, by member employers, or by eligible employees and their dependents.

(7) A person marketing disability insurance policies, certificates, or contracts for a voluntary purchasing pool must be licensed as an insurance producer."

Section 52. Section 33-22-1816, MCA, is amended to read:

"33-22-1816. **Commissioner powers and duties -- application for registration -- reporting insolvency.** (1) The commissioner shall develop forms for registration of an organization as a voluntary purchasing pool.

(2) An organization seeking to be registered as a voluntary purchasing pool shall make application to the commissioner. The commissioner shall register an organization as a voluntary purchasing pool upon

proof of fulfillment of the qualifications provided in 33-22-1815.

(3) ~~On~~ Except as provided in subsection (5), on March 1 of each year, the voluntary purchasing pool shall provide a report and financial statement for the previous calendar year to the commissioner in order that the commissioner may determine:

- (a) whether the operation of the voluntary purchasing pool is fiscally sound;
- (b) whether the voluntary purchasing pool is bearing any risk; and
- (c) the number of individuals covered.

(4) The annual report of the voluntary purchasing pool must disclose its total administrative cost.

(5) A voluntary purchasing pool may choose to operate on a fiscal year other than on the calendar year. A voluntary purchasing pool that establishes a fiscal year that is other than the calendar year shall provide the report required in subsection (3) to the commissioner within 60 days of the voluntary purchasing pool's fiscal yearend."

Section 53. Section 33-23-212, MCA, is amended to read:

"33-23-212. Notice required for cancellation -- statement that insurer will specify reason upon request -- exception -- penalty. (1) Notwithstanding any other provision of this code, ~~no~~ a cancellation by an insurer of a motor vehicle liability insurance policy may not be effective prior to the mailing or delivery to the named insured, at the address shown in the policy, of a written notice of the cancellation stating the date on which, not less than 30 days after the date of such mailing or delivery, the cancellation becomes effective.

(2) ~~No~~ A notice of cancellation of a policy to which 33-23-211 applies may not be effective unless mailed or delivered by the insurer to the named insured at least 30 days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason ~~therefor~~ must be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation must state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than ~~45~~ 21 days prior to the effective date of cancellation, the insurer ~~will~~ shall specify the reason for such the cancellation.

(3) Subsection (2) does not apply to nonrenewal.

(4) Any insurer willfully violating any provisions of subsection (2) of this section is guilty of a misdemeanor and is punishable by a fine not exceeding \$500 for each violation thereof."

Section 54. Section 33-30-107, MCA, is amended to read:

"**33-30-107. Annual statement.** (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on ~~form No. 13~~ the N.A.I.C. health blank form with the commissioner of insurance. This annual statement must be completed in accordance with the national association of insurance commissioners' annual statement instructions. The statement must be accompanied by an actuarial opinion attesting to the insurer's reserves.

(2) The health service corporation shall file a statement containing any other information concerning its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic ~~diskette~~ versions of its annual and quarterly financial statements with the national association of insurance commissioners. The ~~filing~~ date for submission of the annual statement ~~diskette~~ electronic filing is March 1. The ~~filing~~ dates for the other ~~three~~ submission of the quarterly statements statement electronic filing are as follows:

- (i) the first quarter ~~statement~~ filing is due May 15;
- (ii) the second quarter ~~statement~~ filing is due August 15; and
- (iii) the third quarter ~~statement~~ filing is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements.

(4) The commissioner may, after notice and hearing, suspend or revoke a health service corporation's license or impose a fine not to exceed \$100 a day and not to exceed \$1,000 upon a health service corporation that fails to file an annual statement as required by this part."

Section 55. Section 33-30-201, MCA, is amended to read:

"**33-30-201. Reserves -- requirements suspended.** (1) The corporation shall maintain at all times unobligated funds adequate to:

(a) provide the hospital, medical-surgical, and other health services made available to its members and beneficiaries; and

(b) meet all costs and expenses.

(2) In addition, reserves of a health service corporation in cash, certificates of deposit, obligations issued or guaranteed by the government of the United States, or other assets approved by the commissioner ~~shall~~ must be maintained in an amount not less than:

(a) \$500,000; or, if licensed under this chapter after October 1, 1999, \$750,000; or

(b) an amount equal to 1 month's average income from dues or fees paid to the corporation by its members or beneficiaries, based on an average of the preceding 12 months, whichever is less.

~~(3) If the reserves are not equal to the average in subsection (2)(b), they must have been increased during the preceding 12 months by an amount equal to 1% of the gross dues or fee income during that period.~~

~~(4)(3)~~ The determination of minimum reserves is subject, as to amounts payable to participating providers of the health services, to any right of the corporation to prorate the amounts under the terms of its health service contracts with providers.

~~(5) The commissioner may decrease or suspend the requirements of this section if he finds that the action is in the best interest of the members of the corporation.~~

(4) The commissioner may decrease or suspend the requirements of this section if the commissioner finds that the action is in the best interest of the members of the corporation."

Section 56. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to any health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine

and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135; or

(d) network adequacy and quality assurance requirements provided under chapter 36.

(7) ~~Sections Chapter 1, parts 12 and 13, of this title, 33-3-431, 33-15-308, 33-22-141, 33-22-142, 33-22-246, 33-22-247, 33-22-514, 33-22-523, 33-22-524, and 33-22-526~~ apply to health maintenance organizations."

Section 57. Section 33-31-202, MCA, is amended to read:

"**33-31-202. Issuance of certificate of authority.** (1) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to 33-31-201 within 180 days after receipt of the application. The commissioner shall grant a certificate of authority upon payment of the application fee prescribed in 33-31-212 if the commissioner is satisfied that each of the following conditions is met:

(a) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy.

(b) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments. This requirement does not apply to the health care services provided by a health maintenance organization to a person receiving medicaid services under the Montana

medicaid program as established in Title 53, chapter 6.

(c) The health maintenance organization is financially responsible and can reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

(i) the financial soundness of the arrangements for health care services and the schedule of charges used in connection with the services;

(ii) the adequacy of working capital;

(iii) any agreement with an insurer, a health service corporation, a government, or any other organization for ensuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) any agreement with providers for the provision of health care services;

(v) any deposit of cash or securities submitted in accordance with 33-31-216; and

(vi) any additional information that the commissioner may reasonably require.

(d) The enrollees must be afforded an opportunity to participate in matters of policy and operation pursuant to 33-31-222.

(e) Nothing in the proposed method of operation, as shown by the information submitted pursuant to 33-31-201 or by independent investigation, violates any provision of this chapter or rules adopted by the commissioner.

(2) The commissioner may deny a certificate of authority only if the requirements of 33-31-404 are complied with.

(3) The commissioner shall examine each health maintenance organization applying for an initial certificate of authority to do business in this state. In lieu of making an examination under this part of any health maintenance organization domiciled in another state, the commissioner may accept an examination report on the organization prepared by the insurance department of the organization's state of domicile."

Section 58. Section 33-31-211, MCA, is amended to read:

"33-31-211. Annual statements -- revocation for failure to file -- penalty for false swearing. (1) Unless it is operated by an insurer or a health service corporation as a plan, each authorized health

maintenance organization shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and content required by the commissioner and must be completed in accordance with the national association of insurance commissioners' annual statement instructions. The statement must be verified by the oath of at least two principal officers of the health maintenance organization. The commissioner may waive any verification under oath. In addition, a health maintenance organization shall, unless it is operated by an insurer or a health service corporation as a plan, annually file on or before June 1 an audited financial statement. A health maintenance organization's audited financial statement must comply with rules adopted by the commissioner concerning audited financial statements.

(2) At the time of filing the annual statement required by March 1, the health maintenance organization shall pay the commissioner the fee for filing the statement as prescribed in 33-31-212. The commissioner may refuse to accept the fee for continuance of the insurer's certificate of authority, as provided in 33-31-212, may impose a penalty of \$100, or may suspend or revoke the certificate of authority of a health maintenance organization that fails to file an annual statement when due. Each day that the insurer fails to file its annual statement constitutes a separate violation. The total penalty may not exceed \$1,000.

(3) The commissioner may, after notice and hearing, impose a fine not to exceed \$5,000 for each violation upon a director, officer, partner, member, insurance producer, or employee of a health maintenance organization who knowingly subscribes to or concurs in making or publishing an annual statement required by law that contains a material statement that is false.

(4) The commissioner may require reports considered reasonably necessary and appropriate to enable the commissioner to carry out the duties required of the commissioner under this chapter, including but not limited to a statement of operations, transactions, and affairs of a health maintenance organization operated by an insurer or a health service corporation as a plan."

Section 59. Section 33-31-216, MCA, is amended to read:

"33-31-216. Protection against insolvency. (1) Except as provided in subsections (4) through (7), each authorized health maintenance organization shall deposit with the commissioner cash, securities, or

any combination of cash or securities acceptable to the commissioner in the amount set forth in this section.

(2) The amount of the deposit for a health maintenance organization during the first year of its operation is \$200,000.

(3) At the beginning of each succeeding year, unless not applicable, the health maintenance organization shall deposit with the commissioner cash, securities, or any combination of cash or securities acceptable to the commissioner, in an amount equal to 4% of its estimated annual uncovered expenditures for that year.

(4) Unless not applicable, a health maintenance organization that is in operation on October 1, 1987, shall make a deposit equal to the greater of:

- (a) 1% of the preceding 12 months' uncovered expenditures; or
- (b) 4% of its estimated annual uncovered expenditures for each year.

(5) The commissioner may waive any of the deposit requirements set forth in subsections (1) through (4) whenever the commissioner is satisfied that:

(a) the health maintenance organization has sufficient net worth and an adequate history of generating net income to ensure its financial viability for the next year;

(b) the health maintenance organization's performance and obligations are guaranteed by an organization with sufficient net worth and an adequate history of generating net income; or

(c) the health maintenance organization's assets or its contracts with insurers, health service corporations, governments, or other organizations are reasonably sufficient to ~~assure~~ ensure the performance of its obligations.

(6) When a health maintenance organization achieves a net worth not including land, buildings, and equipment of at least \$1 million or achieves a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement under subsection (3) does not apply. The annual deposit requirement under subsection (3) does not apply to a health maintenance organization if the total amount of the accumulated deposit is greater than the capital requirement for the formation or admittance of a disability insurer in this state. If the health maintenance organization has a guaranteeing organization that has been in operation for at least 5 years and has a net worth not including land, buildings, and equipment of at least \$1 million or that has been in operation for at least 10 years

and has a net worth including organization-related land, buildings, and equipment of at least \$5 million, the annual deposit requirement under subsection (3) does not apply. If the guaranteeing organization is sponsoring more than one health maintenance organization, however, the net worth requirement is increased by a multiple equal to the number of those health maintenance organizations. This requirement to maintain a deposit in excess of the deposit required of a disability insurer does not apply during any time that the guaranteeing organization maintains for each health maintenance organization it sponsors a net worth at least equal to the capital and surplus requirements for a disability insurer.

(7) All income from deposits belongs to the depositing health maintenance organization and must be paid to it as it becomes available. A health maintenance organization that has made a securities deposit may withdraw the deposit or any part of it after making a substitute deposit of cash, securities, or any combination of cash or securities of equal amount and value. A health maintenance organization may not substitute securities without prior approval by the commissioner.

(8) In any year in which an annual deposit is not required of a health maintenance organization, at the health maintenance organization's request, the commissioner shall reduce the previously accumulated deposit by \$100,000 for each \$250,000 of net worth in excess of the amount that allows the health maintenance organization to be exempt from the annual deposit requirement. If the amount of net worth no longer supports a reduction of its required deposit, the health maintenance organization shall immediately redeposit \$100,000 for each \$250,000 of reduction in net worth. However, the health maintenance organization's total deposit may not be required to exceed the maximum required under this section.

(9) (a) Unless Subject to subsection (9)(b) and unless it is operated by an insurer or a health service corporation as a plan, each health maintenance organization must have a minimum capital of at least \$200,000 in addition to any deposit requirements under this section. The capital account must be in excess of any accrued liabilities and be in the form of cash, securities, or any combination of cash or securities acceptable to the commissioner.

(b) A health maintenance organization licensed under this chapter after October 1, 1999, must have a minimum capital of at least \$750,000. The amount required to be deposited with the commissioner under subsection (2) must be included in the calculation of the capital needed to meet the \$750,000 minimum.

- (10) Each health maintenance organization shall demonstrate that if it becomes insolvent:
- (a) enrollees hospitalized on the date of insolvency will be covered until discharged; and
 - (b) enrollees will be entitled to similar alternate insurance coverage that does not contain any medical underwriting or preexisting limitation requirements."

Section 60. Section 33-31-301, MCA, is amended to read:

"33-31-301. Evidence of coverage -- schedule of charges for health care services. (1) Each enrollee residing in this state is entitled to an evidence of coverage. The health maintenance organization shall issue the evidence of coverage, except that if the enrollee obtains coverage through an insurance policy issued by an insurer or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation shall issue the evidence of coverage.

(2) A health maintenance organization may not issue or deliver an enrollment form, an evidence of coverage, or an amendment to an approved enrollment form or evidence of coverage to a person in this state before a copy of the enrollment form, the evidence of coverage, or the amendment to the approved enrollment form or evidence of coverage is filed with and approved by the commissioner.

(3) An evidence of coverage issued or delivered to a person resident in this state may not contain a provision or statement that is untrue, misleading, or deceptive as defined in 33-31-312(1). The evidence of coverage must contain:

(a) a clear and concise statement, if a contract, or a reasonably complete summary, if a certificate, of:

(i) the health care services and the insurance or other benefits, if any, to which the enrollee is entitled;

(ii) any limitations on the services, kinds of services, or benefits to be provided, including any deductible or copayment feature;

(iii) the location at which and the manner in which information is available as to how services may be obtained;

(iv) the total amount of payment for health care services and the indemnity or service benefits, if any, that the enrollee is obligated to pay with respect to individual contracts; and

(v) a clear and understandable description of the health maintenance organization's method for

resolving enrollee complaints;

(b) definitions of geographical service area, emergency care, urgent care, out-of-area services, dependent, and primary provider if these terms or terms of similar meaning are used in the evidence of coverage and have an effect on the benefits covered by the plan. The definition of geographical service area need not be stated in the text of the evidence of coverage if the definition is adequately described in an attachment that is given to each enrollee along with the evidence of coverage.

(c) clear disclosure of each provision that limits benefits or access to service in the exclusions, limitations, and exceptions sections of the evidence of coverage. The exclusions, limitations, and exceptions that must be disclosed include but are not limited to:

- (i) emergency and urgent care;
- (ii) restrictions on the selection of primary or referral providers;
- (iii) restrictions on changing providers during the contract period;
- (iv) out-of-pocket costs, including copayments and deductibles;
- (v) charges for missed appointments or other administrative sanctions;
- (vi) restrictions on access to care if copayments or other charges are not paid; and
- (vii) any restrictions on coverage for dependents who do not reside in the service area.

(d) clear disclosure of any benefits for home health care, skilled nursing care, kidney disease treatment, diabetes, maternity benefits for dependent children, alcoholism and other drug abuse, and nervous and mental disorders;

(e) a provision requiring immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of an enrollee or the enrollee's dependents;

(f) a provision providing coverage as required in 33-22-133;

(g) a provision requiring medical treatment and referral services to appropriate ancillary services for mental illness and for the abuse of or addiction to alcohol or drugs in accordance with the limits and coverage provided in Title 33, chapter 22, part 7; however:

(i) after the primary care physician refers an enrollee for treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction, the health maintenance organization may not limit the enrollee to a health maintenance organization provider for the treatment of and appropriate ancillary services for mental illness, alcoholism, or drug addiction;

(ii) if an enrollee chooses a provider other than the health maintenance organization provider for treatment and referral services, the enrollee's designated provider shall limit treatment and services to the scope of the referral in order to receive payment from the health maintenance organization;

(iii) the amount paid by the health maintenance organization to the enrollee's designated provider may not exceed the amount paid by the health maintenance organization to one of its providers for equivalent treatment or services;

(iv) the provisions of this subsection (3)(g) do not apply to services for mental illness provided under the Montana medical aid program as established in Title 53, chapter 6;

(h) a provision as follows:

"Conformity With State Statutes: Any provision of this evidence of coverage that on its effective date is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

(i) a provision that the health maintenance organization shall issue, without evidence of insurability, to the enrollee, dependents, or family members continuing coverage on the enrollee, dependents, or family members:

(i) if the evidence of coverage or any portion of it on an enrollee, dependents, or family members covered under the evidence of coverage ceases because of termination of employment or termination of membership in the class or classes eligible for coverage under the policy or because the employer discontinues the business or the coverage;

(ii) if the enrollee had been enrolled in the health maintenance organization for a period of 3 months preceding the termination of group coverage; and

(iii) if the enrollee applied for continuing coverage within 31 days after the termination of group coverage. The conversion contract may not exclude, as a preexisting condition, any condition covered by the group contract from which the enrollee converts.

(j) a provision that clearly describes the amount of money an enrollee shall pay to the health maintenance organization to be covered for basic health care services.

(4) A health maintenance organization may amend an enrollment form or an evidence of coverage in a separate document if the separate document is filed with and approved by the commissioner and issued to the enrollee.

(5) (a) A health maintenance organization shall provide the same coverage for newborn infants, required by subsection (3)(e), as it provides for enrollees, except that for newborn infants, there may be no waiting or elimination periods. A health maintenance organization may not assess a deductible or reduce benefits applicable to the coverage for newborn infants unless the deductible or reduction in benefits is consistent with the deductible or reduction in benefits applicable to all covered persons.

(b) A health maintenance organization may not issue or amend an evidence of coverage in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an enrollee or dependents from and after the moment of birth.

(c) If a health maintenance organization requires payment of a specific fee to provide coverage of a newborn infant beyond 31 days of the date of birth of the infant, the evidence of coverage may contain a provision that requires notification to the health maintenance organization, within 31 days after the date of birth, of the birth of an infant and payment of the required fee.

~~(6) A health maintenance organization may not use a schedule of charges for enrollee coverage for health care services or an amendment to a schedule of charges before it files a copy of the schedule of charges or the amendment to it with the commissioner. A health maintenance organization may evidence a subsequent amendment to a schedule of charges in a separate document issued to the enrollee. The charges in the schedule must be established in accordance with actuarial principles for various categories of enrollees, except that charges applicable to an enrollee may not be individually determined based on the status of the enrollee's health.~~

~~(7)~~(6) The commissioner shall, within 60 days, approve a form if the requirements of subsections (1) through (5) are met. A health maintenance organization may not issue a form before the commissioner approves the form. If the commissioner disapproves the filing, the commissioner shall notify the filer. In the notice, the commissioner shall specify the reasons for the disapproval. The commissioner shall grant a hearing within 30 days after receipt of a written request by the filer.

~~(8)~~(7) The commissioner may require a health maintenance organization to submit any relevant information considered necessary in determining whether to approve or disapprove a filing made pursuant to this section."

Section 61. Section 33-31-401, MCA, is amended to read:

"33-31-401. Examination. (1) The commissioner may examine the affairs of a health maintenance organization as often as is reasonably necessary to protect the interests of the people of this state. The commissioner shall make an examination at least once every 3 years. The provisions of 33-1-408 and 33-1-409 apply to examinations under this section.

(2) Each authorized health maintenance organization and provider shall submit its relevant books and records for the examinations and in every way facilitate the examinations. For the purpose of examination, the commissioner may administer oaths to and examine the officers and insurance producers of the health maintenance organization and the principals of the providers concerning their business.

(3) (a) Upon presentation of a detailed account of the charges and expenses of examinations by the commissioner, the health maintenance organization being examined shall pay to the examiner as necessarily incurred on account of the examination the actual travel expenses, a reasonable living-expense allowance, and a per diem, all at reasonable rates customary therefor and as established or adopted by the commissioner. The commissioner may present an account periodically during the course of the examination or at the termination of the examination as the commissioner considers proper. A person may not pay and an examiner may not accept any additional emolument on account of any examination.

(b) If a health maintenance organization fails to pay the charges and expenses as referred to in subsection (3)(a), the commissioner shall pay them out of the funds of the commissioner in the same manner as other disbursements of funds. The amount so paid ~~must be~~ is a lien upon all of the person's assets and property in this state and may be recovered by suit by the attorney general on behalf of the state ~~of Montana~~ and restored to the appropriate fund.

(4) In lieu of an examination, the commissioner may accept the report of an examination made by the commissioner of another state."

Section 62. Section 39-8-207, MCA, is amended to read:

"39-8-207. Requirements of licensee. (1) A professional employer organization or group shall, by written contract with the client, establish the responsibilities and duties of each party. The contract must disclose to the client:

(a) the services provided, the administrative fee, and the respective rights and obligations of the

parties;

(b) a statement providing that the professional employer organization or group:

(i) reserves a right of direction and control over employees assigned to the client's location. The client may retain sufficient direction and control over employees necessary to conduct business and without which the client would be unable to conduct business, discharge fiduciary responsibilities, or comply with state licensing laws.

(ii) assumes responsibility for the payment of wages of employees, workers' compensation premiums, payroll-related taxes, and employee benefits from its own accounts without regard to payments by the client; and

(iii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right to accept or cancel the assignment of an employee.

(c) a statement that, with respect to a worker supplied to a client by a professional employer organization or group, the client shares joint and several liability for any wages, workers' compensation premiums, and payroll-related taxes and for any benefits left unpaid by the professional employer organization or group and that, in the event that the licensee's license is suspended or revoked, this liability is retroactive to the client's entering into a contract with the licensee; and

(d) a statement that the client is responsible for compliance with the Montana Safety Culture Act, Title 39, chapter 71, part 15.

(2) The professional employer organization or group shall:

(a) give written notice of the general nature of the relationship between the professional employer organization or group and the client to each employee assigned to perform services at the client's place of work. The disclosure must provide that the professional employer organization:

(i) reserves a right of direction and control over employees assigned to the client's location. The client may retain sufficient direction and control over employees necessary to conduct business and without which the client would be unable to conduct business, discharge fiduciary responsibilities, or comply with state licensing laws.

(ii) retains authority to hire, terminate, discipline, and reassign employees. The client has the right to accept or cancel the assignment of an employee.

(b) submit to the department, within 90 days of the end of each calendar quarter, information

certified by an independent certified public accountant demonstrating that all payroll-related taxes for the quarter have been paid. Upon a showing of reasonable cause, one 30-day extension may be granted for each quarter.

(c) maintain and make available for the department or its agent all records relating to the licensee's business conduct. Records must be maintained for 5 years after terminating an employee leasing arrangement or professional employer arrangement.

(d) notify the department in writing within 20 days of a change of business address or a change in partners, directors, officers, members, or controlling persons designated in the license;

(e) notify the department in writing within 20 days after a client either commences or terminates a professional employer arrangement or an employee leasing arrangement with that professional employer organization or group; and

(f) post the license issued in a conspicuous place in the principal place of business and display, in clear public view in each licensee's office, a notice stating that the professional employer organization or group is licensed and regulated by the department.

(3) When a professional employer organization or group uses a professional employer arrangement with the client, both the professional employer organization or group and the client are the immediate employers of the workers subject to the arrangement for the purposes of the workers' compensation laws of this state. When a professional employer organization or group uses an employee leasing arrangement with the client, the professional employer organization or group is the immediate employer of the workers subject to the arrangement for the purposes of the workers' compensation laws of this state.

(4) A professional employer organization or group shall:

(a) pay wages and collect, report, and pay payroll-related taxes from its own accounts;

(b) pay unemployment taxes, pursuant to 39-51-1103, and provide, maintain, and secure all records and documents required of employers under the unemployment insurance laws of this state. For unemployment reporting purposes, each professional employer organization is the employing unit, as defined in 39-51-201, and shall keep separate records and submit quarterly wage lists for each of its clients.

(c) provide workers' compensation coverage for all employees and provide, maintain, and secure all records and documents required of employers under the workers' compensation laws of this state. A

license may not be issued to a professional employer organization or group until the department receives proof of workers' compensation coverage for all employees assigned to any client location in this state.

(5) A professional employer organization or group is the employer for sponsoring and maintaining employee benefit and welfare plans. The plans, if limited to employees of the professional employer organization or group, are not multiple employer welfare arrangements.

(6) A professional employer organization or group shall disclose to the department, to each client, and to its employees information on any health or life fringe benefit program provided for its employees. The information must include:

- (a) the type of benefits;
- (b) the identity of each insurer providing each type of coverage;
- (c) the amount of benefits for each type of coverage and to whom or on whose behalf the benefits will be paid;
- (d) the policy limits on each insurance policy; and
- (e) whether coverage is fully insured, partially insured, or fully self-funded.

(7) Disclosure required by this section may be made by any written means reasonably calculated to adequately inform the employees, including a summary plan description that meets the requirements of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001, et seq.), as amended.

(8) (a) Subject to any contrary provisions of the contract between the client and the professional employer organization or group, the professional employer arrangement that exists between the parties must be interpreted for purposes of insurance, bonding, and employer liability pursuant to subsection (8)(b).

(b) The professional employer organization or group:

(i) is entitled, along with the client, to the exclusivity of the remedy under both the workers' compensation and employers' liability provisions of a workers' compensation policy or plan of either party; and

(ii) is not liable for the acts, errors, or omissions of a client or of an employee acting under the direction and control of a client, subject to the provisions of this chapter. Subject to the provisions of this chapter, a client is not liable for the acts, errors, or omissions of a professional employer organization or group or of any employee of a professional employer organization or group acting under the direction and

control of the professional employer organization or group.

(9) A professional employer organization that applies for workers' compensation coverage shall also maintain and furnish to the insurer sufficient information to permit the calculation of an experience modification factor for each client employer, including but not limited to:

- (a) the client employer's corporate or business name;
- (b) the client employer's taxpayer or employer identification number;
- (c) the client employer's risk identification number;
- (d) a listing of all employees assigned to each client employer and the applicable classification code and payroll; and
- (e) the client employer's first report of injury identifying the client employer and any other information necessary to permit the calculation of an experience modification factor for each client employer.

(10) An employee assigned to a client by a professional employer organization or group is considered the employee of the client for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, and liquor liability insurance carried by the client. An employee assigned to a client by a professional employer organization or group is not an employee of the professional employer organization or group for purposes of general liability insurance, motor vehicle insurance, fidelity bonds, surety bonds, or liquor liability insurance carried by the professional employer organization or group unless the employee is included by reference in an employment arrangement contract, insurance contract, or bond.

(11) The sale of professional employer services pursuant to this chapter does not constitute the sale of insurance under Title 33 unless the professional employer organization or group:

- (a) undertakes to indemnify another or pay or provide a specified or determinable amount of benefit based on determinable contingencies unless done through a licensed insurer or an employee welfare benefit plan as defined in 29 U.S.C. 1002(1);
- (b) solicits, negotiates, effects, procures, delivers, renews, continues, or binds an insurance policy unless done through a licensed insurance producer; or
- (c) is not exempt under 33-17-103(4).

(12) A sole proprietor or a working member of a partnership working under a professional

employer arrangement may not receive unemployment insurance benefits unless the individual would otherwise be entitled to benefits if the professional employer arrangement did not exist.

(13) If the professional employer organization or group or the client complies with the provisions of 39-71-401 with respect to a worker under the professional employer arrangement, the professional employer organization or group and the client, with respect to those workers, are not uninsured employers, as defined in 39-71-501, and are not subject to the provisions of 39-71-508 or 39-71-515."

Section 63. Section 61-12-303, MCA, is amended to read:

"**61-12-303. Requirements for license.** (1) The commissioner may not issue a license to a company until the company has filed ~~with him~~ the following:

(a) a formal application in ~~such the~~ the form and detail ~~as that~~ as the commissioner may require, executed under oath by its president or other principal officer;

(b) a copy of the form of its contract;

(c) a certified copy of its charter or articles of incorporation and its bylaws, if any;

(d) a financial statement in ~~such the~~ the form and detail ~~as that~~ as the commissioner may require, executed on oath by its president or other principal officer;

(e) a certificate from the commissioner that it has complied with 61-12-304 in all cases ~~where~~ in which a deposit of cash or a bond is required by this part;

(f) ~~if the company is a corporation, a certificate from the corporation-commissioner secretary of the state of Montana, in the event it be a corporation, that it~~ the company has complied with ~~the corporation laws of said state~~ this state's corporate laws.

(2) The commissioner may not issue a license to a company until the company has paid to the commissioner \$100 as an annual license fee; or the pro rata portion ~~thereof~~ of the \$100 necessary to be paid to the end of the current calendar year from the date of the application for the license.

(3) The commissioner may not issue a license to a company until the company has satisfied ~~him~~ by an examination and evidence ~~that~~ that the commissioner may require, ~~in his discretion,~~ that the company has complied with the laws of the state ~~of Montana,~~ and that its management is trustworthy and competent, and that the company is financially responsible."

Section 64. Service contract. (1) Service contract means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair, replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service. A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from power surges or accidental damage from handling.

(2) The marketing, sale, offering for sale, issuance, making, proposing to make, and administration of a service contract is exempt from the provisions of Title 33, except for:

- (a) chapter 1, part 3;
- (b) chapter 1, part 6, excluding 33-1-616;
- (c) chapter 1, part 7; and
- (d) chapter 18.

Section 65. Mechanical breakdown insurance. (1) Mechanical breakdown insurance means a policy, contract, or agreement issued by an authorized insurer that provides for the repair, replacement, or service for the operational or structural failure of the property because of a defect in materials or workmanship or because of normal wear and tear.

(2) The term does not include motor club services, as defined in 61-12-301, or vehicle casualty insurance, as defined in 33-1-206.

Section 66. Prepaid legal plan. (1) For the purposes of this section, prepaid legal plan means the assumption of a contractual obligation that is to be spread directly or indirectly among a group of persons to provide specified legal services or reimbursement for legal expenses in consideration of a specified payment for an interval of time, regardless of whether the payment is made by the beneficiary or by a third person on behalf of the beneficiary.

(2) A prepaid legal plan does not include the provision of or reimbursement for legal services that are incidental to other insurance coverage. The following are not prepaid legal plans:

- (a) retainer contracts made with individual clients with fees based on estimates of the nature and amount of services that will be required;
- (b) contracts made with a group of clients involved in the same or closely related legal matters;
- (c) plans providing only a referral service or a discount card for legal services;
- (d) legal services provided by unions or employee associations to members pertaining to employment or occupation; or
- (e) legal services provided by an agency of state or federal government to employees.

Section 67. Involuntary unemployment insurance. Involuntary unemployment insurance means insurance providing the insured borrower with coverage for consumer credit replacement obligations for a period or periods during which the borrower is involuntarily unemployed. Involuntary unemployment insurance must at least provide benefits for the loss of employment income caused by individual or mass layoff, a general strike, termination by an employer, a dispute involving organized labor, and a lockout.

Section 68. Gap amount -- gap insurance. (1) As used in this section, gap amount means the difference between the amount owed by the lessee or borrower under the purchase or lease agreement in the event of total loss of the personal property prior to the expiration of the agreement by theft or physical damage and the actual cash value or portion received by the lessor or creditor from insurance proceeds or from any other person on account of the total loss or destruction of the personal property.

(2) Gap insurance means insurance covering the gap amount that is payable upon the total loss of personal property, which is the subject of a lease or a loan or another credit transaction, occasioned by the theft of or physical damage to the property.

Section 69. Repealer. Sections 33-2-1311, 33-7-526, 33-22-801, 33-22-802, 33-22-803, 33-22-804, 33-22-805, 33-22-806, 33-22-811, 33-22-812, 33-22-813, 33-22-814, 33-22-815, and 33-22-816, MCA, are repealed.

Section 70. Codification instruction. [Sections 64 through 68] are intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to

[sections 64 through 68].

Section 71. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Section 72. Saving clause. [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before [the effective date of this act].

Section 73. Effective dates. (1) Except as provided in subsections (2) and (3), [this act] is effective October 1, 1999.

(2) [Sections 1 through 4, 31, 66, and 70 through 72 and this section] are effective on passage and approval.

(3) [Section 35] is effective January 1, 2000.

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